



Best Practices for Addressing Combat Operational Stress and Other Behavioral Health Conditions in Marine Corps Substance Abuse Counseling Centers

***Suzanne L. Hurtado
Jenny A. Crain
Robyn M. McRoy
Cynthia M. Simon-Arndt
Gerald E. Larson***



Naval Health Research Center

Report No. 10-25

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government.

Approved for public release; distribution is unlimited.

***Naval Health Research Center
140 Sylvester Road
San Diego, California 92106***

Best Practices for Addressing Combat Operational Stress and Other Behavioral Health Conditions in Marine Corps Substance Abuse Counseling Centers

Suzanne L. Hurtado, MPH
Jenny A. Crain, MS, MPH, CPH
Robyn M. McRoy, MA, MPH, CPH
Cynthia M. Simon-Arndt, MA, MBA
Gerald E. Larson, PhD
Tara M. Smallidge, MBA, PhD

Naval Health Research Center
140 Sylvester Rd.
San Diego, CA 92106-3521

Report No. 10-25 was supported by Headquarters Marine Corps, Quantico, VA, under Work Unit No. 60714. The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. Government. Approved for public release; distribution is unlimited. This research has been conducted in compliance with all applicable federal regulations governing the protection of human subjects in research.

EXECUTIVE SUMMARY

Introduction

In August 2007, the Naval Health Research Center (NHRC) was tasked by Headquarters Marine Corps (HQMC) with assessing the process by which the Substance Abuse Counseling Centers (SACCs) address clients with stress concerns and mental health conditions stemming from deployment, such as Posttraumatic Stress Disorder (PTSD) and Combat Operational Stress (COS). The following Best Practices Report details findings from the scientific literature and SACC site assessments, and provides specific recommendations.

Purpose

The objectives of this report are two-fold: (1) to document the current treatment approach for substance abuse clients with co-occurring mental health concerns at selected Marine Corps SACCs; and (2) review and recommend best practices for screening, referrals, treatment, patient education, and case management. The overall purpose is to provide recommendations that will lead to optimal treatment of SACC clients suffering from PTSD and other military-related mental health conditions.

Procedures

In furtherance of the study objectives, the research team conducted an in-person meeting with local SACC directors, consultants, representatives from HQMC, and project staff. Subsequently, conference calls and visits were made to four sites selected by HQMC and NHRC. Site visits included meetings with counselors, directors, medical officers, Substance Abuse Control Officers (SACOs), and general counseling staff. A site assessment form was developed and used to collect information in the areas of screening, referrals, treatment, materials, and training.

General Findings

Coordination, Programming, and Organizational Factors

Co-occurring disorders among substance abuse clients are becoming the norm rather than the exception, and services must be organized accordingly. This is critical starting with the intake process for new clients, to effective communication and coordination among the various entities

providing the client services. Additionally, a staff well-trained in mental health disorders, particularly PTSD and COS, is important to providing quality services for multiple-needs clients. Recommendations for programming and organizational factors focus primarily on optimizing how the various organizations involved in treating the clients with comorbid substance and psychological conditions can work together.

Identification, Screening, and Assessment

While the need for mental health screening among SACC clients is well accepted, there is not yet a standardized screening process. Each site has its own screening methodology, and they are widely varied. At a minimum, PTSD, depression, and anxiety should be assessed as part of the screening process, and most sites feel that screening for mild traumatic brain injury—which may not have been documented earlier—would be helpful to fully understanding the client’s situation. A variety of screening tools exist; however, recommendations for standardization must fit the SACCs needs and objectives. It is also critical that clients get appropriate feedback from any screening that is used.

Referrals and Treatment

While the criteria for referral are quite varied, SACC counselors are referring clients to a wide range of mental health treatment providers and facilities. Treatment guidelines followed by most SACCs include the NAVMC 2931, MCO P1700.24B, and SECNAVINST 5300.28C, which follow American Society of Addiction Medicine (ASAM) guidelines and Diagnostic and Statistical Manual of Mental Disorders, Version IV (DSM-IV) criteria. Maintaining support networks once a client is referred to residential treatment or treatment outside the military networks remains a universal challenge. Recommendations for referral and treatment focus on standardization and resource development. Standardizing how treatment success and failure are defined, and standardized action plans for reassessing PTSD and substance abuse for return clients, would go along way toward improving client information flow and treatment. Similarly, creating a uniform understanding that the comorbid client is the norm, and standardizing concurrent treatment might be useful. Additional resources, such as additional residential treatment facilities capable of concurrent treatment and comprehensive lists of existing mental health care referral points of contact, are also needed enhancements for treatment services.

Case Management and SACO Coordination

As with many other components of the SACC process, the case management system is driven by the resources available at an individual site. Systematic case management applied to clients with comorbidities can lead to improved comprehensive care, better coordination, and smoother transitions between multiple service providers. Communication is the key to such a system, and electronic systems such as the Armed Forces Health Longitudinal Technology Application have increased communication enhancing the effectiveness of case management at some sites. A clearly delineated Standard Operating Procedure (SOP) should be put into place at each SACC, with guidance provided from HQMC on managing client transfers and deployments. Substance abuse aftercare, psychological referrals, and a method for increasing communication between SACC counselors and unit SACOs should be integrated into the SOP. Unit SACOs should be provided more training on client management, and on issues of substance abuse and PTSD or COS comorbidity that they may encounter. Additionally, the stigma surrounding seeking mental health services must be addressed, so that clients will be more willing to seek help and more likely to communicate honest information that may help with their individual case.

Client Education and Information

Client education and information are critical components of assisting clients in the substance abuse setting with maintaining their treatment plans and understanding and seeking help for any comorbid mental health disorders. While there is no consistent structure to client education across SACCs, most sites make brochures on PTSD and COS available to their clients. Increasing the materials available, and standardizing the recommendations to the field about client education, is strongly recommended.

Resources

This document contains a resource list that we recommend for SACC personnel and clients. Many of these resources are already being used by one or more of the sites that were visited for this project. Others are presented from the current literature on substance use disorders and comorbid mental health disorders.

Overall Recommendations

Taking into consideration the resources available within the constraints of different site characteristics, recommendations are provided in a two-tiered format. The first tier includes the fundamental recommendations which can improve the effectiveness of addressing clients with co-occurring mental health concerns at any SACC site. The second includes supplementary recommendations that are based upon best practices, but which may not be options for every site.

Conclusion

The SACCs have been required by current wartime military operations to enter a new paradigm of treatment for their clients. The overwhelming increase in co-occurring mental health conditions, most notably but not limited to PTSD and COS, has led to a much greater need to understand complex cases, and to integrate services with other treatment entities—such as medical and general counseling. SACCs have been adapting nobly to this process, but it has led to a lack of standardization in structure, assessment, referral, treatment, client education, and case management. The resources available have impacted the level of services provided and the client load is testing the limits of those resources in some cases.

In this evaluation, the research team visited sites selected for their differences to determine the best practices that might be uniformly adapted and implemented among all SACCs. During this process, we discovered many things that were working well, and listened to the counselors voice their opinions about areas for improvement. Universally, there was a call for more resources in the form of training, tools, and collaboration between health care providers. This report details the findings from those site visits, the supporting literature, and, finally, recommendations to optimize referral and treatment of SACC clients with multiple needs.

Table of Contents

Executive Summary	<i>ii</i>
Table of Contents	<i>vi</i>
Chapter One: Introduction	1
Chapter Two: Coordination, Programming and Organizational Factors	9
Chapter Three: Identification, Screening and Assessment of Mental Health Problems	16
Chapter Four: Referrals and Treatment	32
Chapter Five: Case Management and SACO Coordination	48
Chapter Six: Client Education and Information	59
Chapter Seven: Resources	69
Chapter Eight: Overall Recommendations	70
References	74
Appendix A: Combined Tool for Mental Health Screening among SACC Clients.....	86
Appendix B: Defense and Veterans Brain Injury Center (DVBIC) Traumatic Brain Injury (TBI) Screening Tool	89
Appendix C: Patient Placement Criteria Grid	91

Chapter One

Introduction

I. Background

The U.S. military has long viewed substance abuse as a serious health risk, and has focused considerable efforts toward prevention and treatment programs. While at times there have been measureable decreases in heavy alcohol consumption over the past two and a half decades, the most recent Department of Defense (DoD) survey indicates that there has been no significant change in drinking levels from 2002 to 2008 (Bray et al., 2009). In particular, the Marine Corps has typically had the highest percentage of heavy drinkers among all services, and did show an increase between 2005 and 2008. However, the factors associated with beginning or increasing substance use have likely changed since the current wartime posture began.

The stressors of the recent Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) conflicts may be exacerbating existing substance abuse problems among returning war veterans, or causing some service members to begin abusing alcohol or drugs upon the difficult transition home. A 2004 study of Army and Marine Corps personnel recently deployed in support of OIF/OEF found that 35% of deployed personnel sampled had used alcohol more than they intended upon return (Hoge et al., 2004). The 2005 DoD health behaviors survey indicated that, compared with personnel who had not been deployed in the past 3 years, those who had been deployed one or more times had higher percentages of past-month heavy alcohol use and alcohol dependence (Bray et al., 2006). Similarly, preliminary findings from a survey of operational stress and substance use among Marines from Camp Pendleton, California, indicated that personnel who had been combat deployed had higher levels of substance use, including binge drinking, than did personnel who had never been combat deployed (Stander, 2008). The DoD survey also found that deployed Marines had higher rates of illicit drug use than non-deployed Marines.

Thus, many post-deployed Marines will have substance abuse problems. However, the negative health effects of deployments are not limited to substance abuse problems alone. The experience of being a war veteran has numerous effects, and can manifest itself differently in each individual. In fact, the case complexity of the average post-deployed substance abuse client has increased in recent years. A significant number of Marines presenting at Substance Abuse Counseling Centers (SACCs) have considerable levels of Posttraumatic Stress Disorder (PTSD) symptoms, Combat Operation Stress (COS), and other psychological difficulties—such as anxiety and depression. The complexity and varying levels of psychological distress being seen among Marines are consistent with the COS Continuum Model, which indicates that there is a range of symptoms and functioning abilities among Marines with deployment-related stress (COSC, 2008).

The number of U.S. troops diagnosed with PTSD by military health care providers has increased nearly 50% in 2007 over the previous year, as more military personnel serve lengthier and repeated combat tours in Iraq and Afghanistan (Tyson, 2008). The number of U.S. troops diagnosed with PTSD after serving in one of the two conflicts from 2003 to 2007 is estimated at nearly 40,000 (Tyson, 2008). A large study of recently deployed Army and Marine Corps personnel reported that approximately 18-20% of respondents met the broad screening criteria for PTSD, a prevalence nearly double that of a pre-deployment sample surveyed concurrently (Hoge et al., 2004).

The rates of combat stress-related problems are higher among Marines than other service members (Bray et al., 2003), which may, in part, be due to the frequency and intensity of deployments that they and their Army counterparts endure. Marines also have the highest percentage of young, single, enlisted personnel of all the Services—demographic variables that are associated with higher rates of combat stress disorders. In addition, Marines have elevated levels of other health behavior risk factors associated with psychological problems, such as cigarette smoking and hazardous drinking (Bray et al., 2003).

Substance abuse problems and mental health diagnoses are closely associated and often occur together. In fact, clinical and epidemiological research studies conducted on

both civilian and military populations have documented high comorbidity rates of PTSD and substance use disorders. Among civilian populations, prevalence estimates of lifetime substance use disorders have ranged from 21.6% to 43.0% in individuals diagnosed with PTSD, compared with only 8.1% to 24.7% in persons without PTSD (Breslau, Davis, Andreski, & Peterson, 1991; Breslau, Davis, Peterson, & Schultz, 1997; Kessler, Sonnega, Bromet, Hughes, & Selson, 1995). The National Vietnam Veterans Readjustment Study found that, among combat veterans with PTSD, 22% had a current diagnosis of alcohol misuse or dependence, and 75% were estimated to have a lifetime alcohol diagnosis (Kulka et al., 1988). This comorbidity of PTSD with substance use disorders affects men and women differently. Dual diagnosis among patients in substance abuse treatment is 2 to 3 times more common in women than in men (Brown & Wolfe, 1994; Najavits et al., 1998). Often, the substance abuse problem is a result of PTSD, and this temporal understanding can be helpful in the identification of onset, assessment, and shaping of treatment programs (Tanielian & Jaycox, 2008).

Veterans who begin using alcohol or drugs after deployment may be using substances as a way to self-medicate—thereby reducing trauma-related thoughts and emotions—as the use of substances such as alcohol, marijuana, heroin, and benzodiazepines can initially improve PTSD symptoms (Jacobsen, Southwick, & Kosten, 2001; Bremner, Southwick, Darnell, & Charney, 1996). However, the physiological response resulting from substance withdrawal “may have an additive effect with arousal symptoms stemming from PTSD” (Jacobsen et al., 2001). As a result, combat veterans who attempt to reduce or stop their substance abuse may experience heightened PTSD symptoms and abandon substance abuse treatment. Furthermore, individuals with co-occurring mental health and substance abuse disorders have been shown to have more severe symptoms and poorer health outcomes after treatment (Greenfield et al., 1998; Olfson et al., 1997; Ormel et al., 1994; Shalev et al., 1998). For both of these reasons, it is critical that substance abuse counseling and treatment programs must be aware of their clients’ psychological issues in order to develop the most effective treatment plans and appropriate referrals.

This evidence of the association between substance abuse and mental health

conditions such as COS and PTSD, and the issues regarding substance abuse treatment, highlights the need for thorough PTSD screening for war veterans who seek help for alcohol or substance abuse issues.

Marine Corps Community Services Programs and Concern

The mission of the Marine Corps Community Services Substance Abuse Programs is to provide Marine Corps plans, policies, and resources to improve and sustain the commanders' capabilities to provide opportunities to prevent (substance abuse) problems, which detract from unit performance and readiness. The specific goal of the SACC program is to provide drug and alcohol services including screening, early intervention, comprehensive biopsychosocial assessments, and individualized treatment using a continuum of care model. Guidelines for the programs were developed during peacetime, and the question of whether the treatment approaches currently in use meet the needs of combat-deployed Marines and their families has been raised. As yet, there have been no formal assessments as to how the programs are equipped for wartime and the mental health problems that may surface, or be exacerbated, by the stressful experiences of war.

II. Aim and Objectives

As part of Headquarters Marine Corps' effort to ensure that their Substance Abuse Programs have fully transitioned to a wartime footing, the Naval Health Research Center (NHRC) has been tasked to conduct an assessment of the SACC's ability to detect and mitigate wartime-related mental health problems. This report's objectives are two-fold: (1) to document the current treatment approach with regard to substance abuse clients with co-occurring mental health concerns at selected Marine Corps SACCs; and (2) review and recommend best practices for screening, referrals, treatment, patient education, and case management.

III. Methods

The site assessment planning process began with an initial meeting, held at NHRC, with three local SACC Directors, NHRC staff, consultants, and representatives from Headquarters Marine Corps. The purpose of this meeting was to discuss perceptions of the problem and define the issues. Individual conference calls were later held with each of the four selected sites, and this was followed with a 2-day site visit to meet with counselors, directors, medical officers, Substance Abuse Control Officers (SACOs), and general counseling staff. A site assessment form was developed and used to collect information in the areas of screening, referrals, treatment, materials, and training. Copies of all client administrative and educational materials were obtained.

Summary results of the SACC site assessments are included in this report. In addition, a literature review was conducted to identify supporting evidence for best practices in each area identified from the site visits and other external programs. The site assessment and literature were then synthesized to develop core principles and lessons learned for each section of the report. Each section concludes with a list of recommendations and improvement opportunities.

IV. Site Characteristics

Four Marine Corps SACCs were selected for assessment of their treatment approach and current practices regarding clients with co-occurring mental health or combat operational stress concerns. The sites were selected by Headquarters Marine Corps and NHRC to represent a range in size, services, and resources. Two of the selected SACC were located on small bases and conducted few substance abuse screenings per week, while the other two sites were on larger bases with more counselors and on-site medical resources (see Table 1). While all sites do have an on-base medical clinic or hospital to which they refer their clients with mental health concerns for further evaluation and assistance, one of the smaller sites refers all of their clients with mental health concerns to off-base civilian psychologists and psychiatrists due a lack of on-base specialists. In terms of residential treatment for alcohol dependence, Table 1 shows the distance to the nearest referral resource.

Table 1
SACC Site Characteristics¹

Site characteristic	Site A	Site B	Site C	Site D
SACC screenings per week or month	3-4/month	2-3/week	11-14/week	45-50/week
SACC clients in outpatient treatment	5	12	*	45
Active-duty personnel served by SACC	400	15,000	9,000-12,000	35,000
Full-time SACC counselors	1	3.5	2.5 (with 2 additional vacant positions)	14
Licensed independent practitioners/medical officers on-site at SACC	0	0	1	2
Type of on-base medical facility/Provides mental health care?	Branch Medical Clinic/No	Branch Medical Clinic/Yes	Naval Health Clinic/Yes	Naval Hospital/Yes
Approximate distance to nearest substance abuse residential treatment facility (military or civilian)	10 miles (civilian)	8 miles (military)	114 miles (civilian)	42 miles (military)

¹ Figures in Table 1 are best estimates provided by SACC Directors at the time of the site assessment.

* Estimate not available.

V. SACC Background Relevant to Mental Health Concerns

All the sites reported seeing an increase in the number of SACC clients with COS, PTSD or other mental health concerns since the start of the Iraq and Afghanistan conflicts, but not necessarily an increase in the overall number of SACC clients. Half of the sites report that they have seen an increase in the number of SACC clients, and the other half report that the complexity of their clients has increased as many present with comorbid concerns. For example, at Site B, of the 120 clients that were screened in 2007, 5% had a psychotic disorder or other injury that was affecting their mental health and

10% had an anxiety disorder. By August 2008, the Site B SACC was seeing an increase in the number of clients with PTSD concerns. They were also seeing Traumatic Brain Injury (TBI) and schizophrenia more often among their clients. About 25% of SACC clients at Site D have had a PTSD diagnosis, COS symptoms, or TBI, and they are seeing more depression. The SACC at Site A reports that about 30% of their clients have had PTSD symptoms. Site C reports seeing more depression, anxiety, sleeping problems, acute stress, and suicidal ideations, and an increase in agitation, irritability, shaking, and night sweats.

All sites report that the types and patterns of substance abuse have also changed with Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF). Sites B and D are seeing more prescription medication abuse (for example chronic pain management medications and opiates). Site C also reports an increase in prescription drug abuse, as well as illegal drug use, specifically cocaine and marijuana, and an increase in heavy alcohol use and underage drinking.

The site counselors theorize that the increase seen in substance abuse and comorbid concerns is due to the marked increase in the number of repeat deployments. However, at the same time, two sites noted that some of the substance abuse increases and comorbid concerns may be attributable to trauma experienced by the client earlier in life (and not from recent combat exposure). One counselor noted that it is only now becoming obvious in the military substance abuse treatment field that some service members, who have already experienced PTSD symptoms as a result of tumultuous childhood experiences, are more vulnerable to PTSD later in life. The counselor also added that pre-service substance abuse may be contributing to post-deployment PTSD and substance abuse problems. Counselors at Site C note that it is difficult to assess for pre-existing trauma; most SACC clients deny any history of abuse.

The substance abuse counselors also indicated that the effects of multiple deployments have a significant impact on young marriages and dependent families. SACC clients often experience family disruption and relationship problems. In fact, there are many cross-referrals from general counseling and Family Advocacy Program (FAP) to the SACCs. At Site C, about 33% of FAP clients are also SACC clients. At Site D,

they are seeing an increased number of referrals to the SACC from their on-base Naval Hospital Mental Health Unit.

Chapter Two

Coordination, Programming and Organizational Factors

I. Site Information

In general, the SACCs fall under Counseling Services within Marine and Family Services, Marine Corps Community Services (MCCS) at their respective bases. The Substance Abuse Program operates with other counseling services that are provided such as the FAP and General Counseling. SACC Directors report to the Head of Marine and Family Services. In some other cases, the SACC does not fall under Marine and Family Services; they are directly under MCCS. Regardless of the parent organization, the SACCs must coordinate with other counseling services, medical facilities, and mental health care providers to provide the highest quality care.

Coordination with other counseling services: All sites indicated that they receive referrals from other programs such as FAP and general counseling. It is common that clients experience difficulties maintaining various domestic and work-related responsibilities, resulting in family and relationship problems. At Site C, about 33% of FAP clients are also SACC clients. At Site D, counselors are seeing an increase in the number of referrals to the SACC from their on-base mental health unit. Because of these cross-referrals, the sites noted that developing a good working and collegial relationship among the various counseling services is critical to providing the highest quality care. In terms of physical organization, it was also strongly recommended that all counseling services be housed in one facility. This allows a counselor to physically walk a referred client to the next counselor in another counseling program, thereby reducing the risk of a no-show to the referral and creating a more client-centered cohesive system.

Coordination with military mental health treatment: Because the SACCs do not fall under the same organizational structure as the Navy medical facilities, and—in particular—mental health care, it is critical that these separate entities communicate and

coordinate to provide the best care for their clients with comorbid issues. To enhance this communication, periodic meetings between the SACCs and mental health care providers are held at the two larger sites. At Site D, there is a coordination meeting held once a month at the Family Services Center involving the local stake-holders including general counseling services, the Mental Health Unit (MHU), specific Marine division psychiatry professionals, and the SACC. At Site C, once a quarter there is the Mental Health Advisory Board meeting to enhance collaboration between mental health care providers and the SACC. The SACC at Site B indicated that they do not have periodic meetings with mental health services—mainly because the Navy Medical and MHU on the installation are short-handed and over-tasked. They not only serve their base, but also another large base in the area. When Site B has a client that has a co-existing disorder, they collaborate with MHU to ensure that the SACC services delivered are not counter-indicated. They also have this relationship with their local Naval Hospital MHU.

However, two sites noted that one of the obstacles to open communication between these two groups is that the medical clinic won't release any patient information to the SACC counselors, only to other medical personnel, due to *Health Insurance Portability and Accountability Act (HIPAA)* regulations.

New clients: An important factor to consider in determining if a center is organized to address individuals with multiple needs is to look at how they take in new clients. Most sites reported that Marines enter the substance abuse program primarily through command referrals stemming from an alcohol-related incident, rather than self-referral. The counselors report that the clients often feel intimidated during their first encounter with the SACC, particularly those clients who may have co-occurring mental health concerns. One of the sites reported that they have structured their services to address this tension by having their administrative professional sit with each new client and go through the intake forms as they input information into the computer. The site reported that this process helps to put clients at ease. Specific processes or organizational structures designed to create a welcoming environment for clients was not noted in the other three site assessments.

Staffing and credentials: Of the two larger sites, one has 14 substance abuse

counselors who are mostly retired Navy and Marine Corps personnel with diverse backgrounds; the other site currently has only 2.5 full-time counselors with two vacancies. At the two smaller sites, one full-time counselor is employed at one SACC and 3.5 counselors are employed at the other. In some cases, SACC Directors also serve as part-time counselors when needed. At the smaller sites, some SACC counselors share counseling responsibilities with general counseling or FAP, as the client loads of these programs shift.

Regarding medical personnel, the largest SACC has two on-site licensed independent practitioners (LIPs): an active-duty Navy psychiatric nurse practitioner and a licensed clinical social worker. The other large site has one on-site medical officer. The smaller sites do not have on-site medical officers; clients receive a referral from the SACC to go to the on-base clinic to see a practitioner for diagnosis, treatment authorization, or additional referrals. However, at one of the smaller sites, one of the counselors holds both a clinical supervisor certification, and is a licensed professional counselor working under supervision, so they do act in the capacity of a LIP at times. In terms of additional staff, the largest site has two substance abuse prevention specialists and one drug demand reduction specialist (DDRC). Another site holds a billet for a DDRC and an alcohol abuse prevention specialist; however, instead of filling those positions directly, the site's substance abuse counselors hold the Navy Prevention Specialist Certification, and—as such—they develop prevention plans and deliver prevention presentations.

Two of the sites expressed that the requirement for substance abuse counselors to be Navy certified (Department of the Navy [DON], 2001 [paragraph 5017 of MCO P1700.24B]) inhibits their ability to hire new counselors. One site indicated that the Navy preceptor program was helpful in this area, as part of the preceptor's responsibilities is to provide intern training relevant to Alcohol and Drug Counselor (ADC I) certification, and to keep counselors current with regard to certifications.

Accreditation: The Commission on Accreditation of Rehabilitation Facilities (CARF) provides accreditation to the independent Marine Corps SACC facilities. Site B recently attained their CARF accreditation, and the site noted that this came with a new

requirement to conduct a client satisfaction questionnaire for feedback. U.S. Navy substance abuse program sites use the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for their accreditation, and one site indicated that these two accreditation processes moving in tandem will improve services. Site D is in the process of attaining their CARF accreditation, and also plans to complete JCAHO accreditation. The smallest SACC site indicated that they do not need to attain specific independent accreditation, but that they do receive routine Inspector General inspection.

II. Supporting Evidence/Literature

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing substance disorder services for individuals with co-occurring mental health disorders is designed to improve the scope of treatment and integration in centers of any size and complexity (Minkoff & Cline, 2004). The overall model seeks to create comprehensive system change, make efficient use of existing resources, incorporate clinical best practices, and implement an integrated treatment philosophy that makes sense from both mental health and substance disorder perspectives. In terms of organizing substance abuse services that address comorbid mental health concerns, the model points to several useful research-derived principles.

The care facility should expect that their substance abuse clients will have co-occurring mental health concerns. Dual diagnosis patients should be considered the expectation, rather than an exception (Minkoff & Cline, 2004). The epidemiologic evidence showing the close association between PTSD and substance abuse problems (Breslau, Davis, Andreski, & Peterson, 1991; Breslau, Davis, Peterson, & Schultz, 1997; Kessler et al., 1995) implies that the whole treatment system should be organized to use all of its resources in accordance with this expectation. There is the need for integrated system planning where services and all clinician competencies are designed to address individuals with co-occurring disorders.

In accordance with the anticipation that clients will have multiple needs, the facility should display a welcoming and empathic environment that eliminates arbitrary barriers to an initial evaluation and helps the client connect with the appropriate program

(or programs) as quickly as possible (Minkoff, 2008a). This includes conducting screening for co-occurring disorders at initial contact with the system. Similarly, the facility's staff should also convey a hopeful and empathic attitude. At times, "both in the culture at large and among clinicians, views of patients with substance abuse and/or PTSD may be quite negative," and "counter-transference reactions are common" (Hernan, 1992; Imhof, 1991; Imhof, Hirsch, & Terenzi, 1983; Najavits et al., 1995). Therefore, counselors need to empathize with their clients' reality of despair and emphasize a hopeful vision for recovery.

Being able to provide quality services for multiple needs clients depends on having well trained staff. However, counselors and clinicians who treat clients with substance abuse disorders and comorbid mental health disorders usually have expertise in either substance abuse or mental health, but not both. The *Seeking Safety* manual indicates that "substance abuse counselors are not typically trained to work on severe mental health problems, and thus PTSD may be ignored or misunderstood" (Najavits, 2002). The *Handbook for Mental Health and Substance Abuse Professionals* (Hendrickson, Schmal, & Ekleberry, 2004) points out that directors need to identify their staff's knowledge and skill gaps in these areas, and promote training opportunities to fill these gaps. Specialized training should be conducted on site (Minkoff & Cline, 2004; Minkoff, 2008b; Hendrickson et al., 2004); this allows staff members to attend the sessions together and process their understanding of the new information with one another. Supervisors then need to offer reinforcement of the newly acquired information and allow for time to practice new skills. The Substance Abuse and Mental Health Services Administration (SAMHSA) treatment improvement protocol on substance abuse treatment for persons with co-occurring disorders underscores the "importance of creating a supportive environment for staff and encouraging continued professional development, including skills acquisition" (U.S. Department of Health and Human Services [HHS], 2005). In the CCISC model, it is recommended that training must be ongoing and tied to actual job performance. A training plan that involves opportunities for advanced certifications and experiential learning is recommended.

The SACC's internal organizational structure, collaboration with other entities, and specific COS/PTSD training and professional development for staff all play an important role in the center's ability to provide quality substance abuse treatment and mental health screening, with the ultimate aim of restoring the service member to full duty.

III. Core Principles/Lessons Learned

- Substance abuse programs should expect that clients will have co-occurring disorders, and, as a result, organize their services in accordance with this expectation, including having processes in place that handle new clients in a welcoming and empathic manner.
- A good working and collegial relationship among the various counseling services is vital to providing the highest quality care. Housing all the counseling services in one facility enhances this coordination, and presents a more client-centered, cohesive system.
- It is critical that substance abuse programs and medical/mental health care providers, both in separate organizations, communicate and coordinate to provide the best care for their clients with comorbid issues.
- A well trained staff is important to providing quality services for multiple needs clients. SAMHSA guidelines emphasize the importance of creating a supportive environment for staff, and encouraging continued professional development, including skills acquisition in both the areas of substance abuse and mental health issues.

IV. Recommendations/Future Directions

- Create specific processes to welcome clients at the SACC. Counselors should anticipate that many of their substance abuse clients may also have co-occurring mental health concerns.

- Co-locate SACC and other counseling services. This will increase communication and cross referrals between the counseling programs, and facilitate providing multiple services to clients.
- Enhance communication between the SACC and mental health providers at on-base medical facilities by holding monthly meetings between these two groups and all other key stakeholders.
- Identify SACC staff knowledge and skill gaps in mental health/COS/PTSD, and promote training opportunities to fill these gaps. SACC directors should empower their front line people, the counselors, who are encountering clients with multiple needs.

Chapter Three

Identification, Screening, and Assessment of Mental Health Problems

I. Site Summaries

Site A:

At Site A, the SACC counselors allow 90 minutes for intake; however, it usually only takes an average of 30 minutes to complete the current screening process. The first phase (occurring on day 1) includes administration of the Alcohol Use Disorders Identification Test, the Posttraumatic Stress Disorder Checklist (PCL), and the biopsychosocial assessment (see Table 2). The next phase (occurring on day 2) is typically a more in-depth assessment of “red flag” issues that were noted during the initial meeting.

This SACC had a number of recommendations that would improve the screening process. The assessment process is time consuming, particularly if a client has mental health problems. Counselors indicate that more clinicians are needed particularly at the larger bases. It was also noted that demographic information should be listed on all assessment forms and not just on the front page. Additionally, there is no standard documentation to screen clients for any indications of TBI. The only way counselors know of this condition is if the client tells them, or if the counselor requests this information from medical. Counselors commented that there should be more routine screening and identification of PTSD before symptoms manifest, which is the main reason for referrals.

Site B:

Counselors at Site B indicate that there are a series of steps taken to obtain information from a new SACC client. The initial step is to review the client’s medical record and military service record. The pre-deployment health assessment screening,

which includes a section where a physician may have flagged the individual for PTSD or suicidal ideation, should be reviewed. Based on the initial screening, counselors may also screen for depression, anxiety, and mood disorders (see Table 2). The Posttraumatic Disorders Checklist – Civilian Version (PCL-C) is also used as a screening tool, albeit inconsistently.

The duration of the screening process depends on the substance abuse incident, but typically includes 45 minutes of paperwork, followed by 30 minutes of initial contact time. The follow-up visit consists of one hour of in-depth psychosocial assessment, followed by 30 minutes to 1 hour to develop a treatment plan with a SACC counselor.

It was noted that the USMC Recruiter School uses an on-line/electronic screening tool for a variety of purposes. However, this on-line screening tool does not always identify individuals who are suffering from PTSD. Counselors have noted that many Marines try to protect their careers as instructors, a high profile position, and may, therefore, be guarded in their responses.

Site C:

The intake process and screening process at Site C takes 30-90 minutes, with an average of 45 minutes. The FAP at this site indicated that more than 60% of their clients have been in a combat environment, and a similar percentage is estimated among SACC clients. If clients answer “yes” to the question “have you ever been deployed to a combat environment” in the initial screening process, the center will administer the Posttraumatic Disorders Checklist – Military Version (PCL-M) (see Table 2). If the client scores a 41 or higher, they will be referred to medical. A PCL-M score of 30 or higher is considered a “red flag,” and the client will be monitored by the SACC. The counseling center also screens for anxiety disorders.

The center at this site uses an electronic database to collect and document information. The database allows the SACC to quickly answer any questions regarding trends and number of cases. The client database contains suicide information, military background information, deployment history, and diagnoses. An administrative assistant

at Site C sits with the client and documents their information during the intake phase; this typically takes 10 minutes to complete. The counselors also fill in a section of the database after the visit.

Site D:

The SACC at Site D uses the PCL-M and occasionally the PTSD Symptom Scale-Self Report for the initial screening process (see Table 2). The LIP screens 50-60 clients per week. The initial inpatient screening is supposed to take 30 minutes; however, counselors indicate that the process typically takes 45 minutes, in part because other issues, such as PTSD and TBI, are being examined. The counseling center's goal is to complete the intake, screening, LIP meeting, and assessment all in the same day. In addition, the counseling center is taking steps to have 100% of their intake forms automated.

Counselors screen individuals for TBI if they were exposed to an explosion or blast. If a client is suspected of experiencing TBI, they will be referred to the concussion clinic where an MRI, blood and liver tests, and consultations with neurology will be conducted. Prior to current military operations, counselors saw complex cases approximately every six months, however now they are more of the norm. If clients are self-referred, counselors have no previous information on the client.

Individuals who have been assessed as substance abusers are referred to the LIP for confirmation. If individuals are confirmed as having a substance abuse diagnosis, there is typically a one-week waiting period from the initial patient screening until they begin outpatient treatment. If the client requires inpatient treatment, it can take as long as 29 days from the date of the initial incident to enter local Navy residential treatment.

Table 2

SACC Screening and Assessment Forms for Substance Abuse and Mental Health*

	Site A	Site B	Site C	Site D
Substance Abuse				
Substance Abuse Clinical Package- NAVMC 2931	x	x	x	x
Comprehensive history of alcohol and drug abuse		x	x	
Drug Abuse Screening Test			x	
Medical record review		x	x	x
Assessment of current medications	x	x	x	x
Withdrawal assessment	x		x	
Alcohol Use Disorders Identification Test (AUDIT)	x		x	
Mental Health				
Deployment history item	x	x	x	x
PTSD Checklist (Military or Civilian)	x	x	x	x
Other PTSD screening (PTSD Symptom Scale-Self Report, Primary Care PTSD Screen)	x			x
Mental Health Status Form	x			
Depression screening (Beck Depression Inventory, Hands Depression Screening tool)	x		x	x
Suicidal Risk and Ideations Assessment			x	
Contract against suicide, self-harm, or harm to others			x	
Anxiety disorder screening	x	x		x
Mood disorder screening	x	x		

*Table does not include SACC administrative forms such as Client Orientation Checklist, Emergency Information Form, privacy act, consent forms, Client Satisfaction Questionnaire, Client Rights and Responsibility Form, and other administrative forms.

II. Supporting Evidence/Literature

Although standardized screenings and assessments for substance abuse have been implemented across the Marine Corps Substance Abuse Counseling Centers (NAVMC 2931 and MCO 1700.24B), a presenting challenge is that there is no similar standardization for mental health screening. The need for consistent and standard measures for mental health screening is imperative as it can impact the accuracy of psychological problem identification. The screening process ensures that service members at risk for severe problems, such as those with PTSD, major depression, or other mental health problems, are identified and treated before a crisis situation develops. Mental health screening also provides SACC counselors with a better understanding of the whole person they are treating, and how the client's mental health may be associated with their substance abuse problem.

Many mental health screening tools have been recommended in the literature, and we recommend that three specific mental health screening tools be integrated into SACC screening and assessment across all SACC locations. These screening tools were chosen based on the following criteria for selecting mental health screening tools in the SACC environment:

- (1) The goal of mental health screening at the SACC is to achieve appropriate referral, not diagnosis, clinical research, or outcome assessment (Najavits, 2004).
- (2) The tools accurately assess symptoms related to common mental health problems that occur among military SACC clients.
- (3) There are practical limitations inherent to the screening environment including heavy counselor workloads, shortage of qualified staff (understaffed), and a lack of psychopathology training (Najavits, 2004).
- (4) Clients may be unwilling or unable to answer lengthy screening questionnaires (Najavits, 2004).
- (5) Screening tools need to be available in the public domain, or legally reproducible for clinical purposes.

- (6) Screening tools need to be easy for SACC counselors to administer and interpret.
- (7) SACCs are already screening for substance use disorders and issues; new tools should not replicate anything that is already being done.
- (8) The literature supports use of the tools for substance abuse clients or in substance abuse counseling settings.
- (9) Screening tools should be validated to accurately assess the variety and severity of symptoms that individuals with mental health problems may be experiencing (Gahm & Lucenko, 2007).

Although many different types of mental health disorders commonly co-occur with substance use problems, an extensive literature review provides rationale for three areas in which additional mental health screens are critical for military personnel with substance use problems: PTSD, depression, and anxiety. One additional area, mild Traumatic Brain Injury (mTBI), is recommended as an optional tool for counselors. The rationale for screening for these three disorders, along with the recommended screening tools, is discussed in detail below. (See Appendix A for our recommended screening form; we have combined the PTSD, depression, and anxiety screening questions onto one form for ease of use.)

Mental Health Disorders and Recommended Screening Tools

PTSD

PTSD has been shown to be commonly comorbid with substance abuse problems (Kulka et al., 1990; Grant et al., 2004). For this reason, it is highly recommended that all substance abuse patients be routinely screened for PTSD (Ouimette, Brown, & Najavits, 1998; Najavits, 2004; Kennedy, Jones, & Grayson, 2006), so that individuals with multiple disorders receive concurrent support and treatment (Ouimette et al., 1998; Abueg & Fairbank, 1991; Brady, Killeen, Saladin, Dansky, & Becker, 1994; Brown, Recupero, & Stout, 1995; Brown, Stout, & Mueller, 1999; Ruzek, Polusny, & Abueg, 1998; Najavits, Weiss, & Liese, 1996b).

We recommend that the PCL-C be used to assess PTSD in SACC clients (Weathers, Litz, Huska, & Keane, 1994). The PCL-C is 17 questions, and takes approximately 5 to 10 minutes to administer (Weathers et al., 1994). The PCL-C is in the public domain, may be reproduced, and requires no special training to administer (Weathers et al., 1994; Najavits, 2004). It may be acquired online at <http://www.pdhealth.mil/guidelines/appendix3.asp>.

Several other PTSD symptom scales have been recommended in the literature. These include the Screen for Posttraumatic Stress Symptoms (Carlson, 2001) suggested in the Iraq War Clinician Guide (National Center for Posttraumatic Stress Disorder, 2004), the PTSD Symptom Scale Self-Report (by Foa, Riggs, Dancu, Rothbaum, 1993) suggested by Read, Bollinger and Sharkansky (2003), and the Posttraumatic Diagnostic Scale by Foa, Cashman, Jaycox, & Perry, 1997) suggested by Read et al., 2003. Nevertheless, the PCL (Weathers, Litz, Herman, Huska, & Keane, 1993) was chosen because it has also been highly recommended as a screening tool for PTSD among military populations (Kennedy et al, 2006; Najavits, 2004; Read et al., 2003; National Center for Posttraumatic Stress Disorder, 2004), and all four SACCs that were interviewed as part of our assessment already use a version of the PCL, thus counselors are already familiar with this tool.

The literature is somewhat mixed as to which version of the PCL is best for military populations. Although some research specifically recommends the PCL-M (Weathers, Huska, & Keane, 1991; Weathers et al., 1993) for military populations (suggested by Kennedy et al., 2006), other sources have recommended the PCL-C (Weathers et al., 1994; Najavits, 2004; Read et al., 2003; National Center for Posttraumatic Stress Disorder, 2004). The only difference between the PCL-M and the PCL-C is that questions in the PCL-M refer to "a stressful military experience" while questions in the PCL-C are not linked to a specific event but rather to "a stressful experience from the past"). As explained in the Iraq War Clinician guide, the PCL-C does "not key symptoms to a particular event, since exposure to multiple events is common and it is not clear that people can assign symptoms to events with any accuracy or that symptoms are, in fact, uniquely associated with particular events" (National Center for

Posttraumatic Stress Disorder, 2004). Therefore, the PCL-C is recommended in the military substance abuse counseling setting so that SACC counselors can assess problems related to both military and nonmilitary traumatic experiences. For example, the PCL-C tool may facilitate the counselors to explore symptoms that stem from non-combat-related trauma (e.g., personal or sexual assault), and may allow for better placement in tailored group treatment.

The 17 questions in the PCL-C correspond to the 17 DSM-IV symptoms of PTSD and include symptoms such as, “Repeated, disturbing memories, thoughts, or images of a stressful experience,” “Avoiding activities or situations because they reminded you of a stressful experience,” and “Trouble falling asleep or staying asleep” (Weathers et al., 1994). Respondents rate how much they were “bothered by each problem in the past month.” Items are rated on a 5-point scale ranging from 1 (“not at all”) to 5 (“extremely”) (Weathers et al., 1993). Overall scores are calculated by adding up all the scores from each item, and can range from 17 to 85. We suggest using a score of 50 or higher for referral to a mental health practitioner. This score is consistent with recommendations by Weathers and colleagues (1993) based on their findings among a sample of Vietnam veterans. Detailed directions for the administration and scoring of this tool are available at http://www.pdhealth.mil/guidelines/downloads/PCL_Primer.pdf.

Depression

Depressive disorders have been a leading cause of disability in the general U.S. population for several decades—costing millions of dollars in health care and lost productivity (National Institute of Mental Health, 2007; Greenberg, Kessler, Nells, Finkelstein & Berndt, 1996). Research has shown that the military population is not exempt from this issue, as illustrated by the results of a recent study which found that of 101,000 Marine Corps personnel, 4.7% had been diagnosed with a depressive disorder (Larson, Highfill-McRoy, & Booth-Kewley, 2008). In fact, depression has become one of the most commonly reported concerns in service members returning from combat (Hoge et al., 2004). As with PTSD and anxiety, a strong link between depressive disorders and substance abuse has been established (Helzer & Pryzbeck, 1988; Kessler et al., 1997;

Meyer & Kranzler, 1990). Consequently, it is recommended that all patients seeking treatment for substance abuse are immediately screened for depression upon intake (Quello, Brady, & Sonne, 2005).

For initial assessment of depressive disorders at SACCs, we recommend using a validated screening tool, the Patient Health Questionnaire 9 (PHQ-9) (Kroenke, Spitzer, & Williams, 2003). The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Beck, Steer, & Brown, 1996) and the Beck Depression Inventory Short Form (Beck & Beck, 1972) are used by some SACC counselors, and it has been recommended for use for War Veterans (National Center for Posttraumatic Stress Disorder, 2004). However, the PHQ-9 is recommended over the BDI because the PHQ-9 is also widely used in military environments (Felker, Hawkins, Dobie, Gutierrez, & McFall, 2008; Levin, 2008; Warner, Breitbach, Rachal, Matuszak, & Grieger, 2007; Douglas, Taylor, O'Malley, 2004; Kroenke, Spitzer, & Williams, 2001; U.S. Department of Defense Military Health System, 2008), and because it has comparable psychometric properties and well proven scientific evidence to support it as a good screening tool for depression. Most importantly, from a practical standpoint, the PHQ-9 is freely accessible to the public, whereas the BDI is a registered trademark of Pearson Education, Inc., and any reproduction of the BDI scale would be an infringement of the copyright (<http://pearsonassess.com/haiweb/Cultures/en-US/Site/general/LegalPolicies.htm>).

The first two items of the PHQ-9 are designed to detect the presence of depression, and are referred to as the PHQ-2 (Kroenke et al., 2001). If a patient does not mark “not at all” on both of these two items, they should be administered the remaining items on the PHQ-9, which can provide information as to the severity and type of depression (Kroenke et al., 2001).

If a client marks “more than half the days” in either of the first two questions and also checks “more than half the days” or “nearly every day” for at least five questions total (including the first two), the client should be referred to a mental health provider for further assessment. If a client marks “more than half the days” in either of the first two questions and also checks “more than half the days” or “nearly every day” for two to four questions total (including the first two), the counselor should discuss this with the client

and use his or her clinical judgment to decide if referral is necessary. This scoring is consistent with recommendations made by the authors (Kroenke et al., 2001).

The PHQ-9 is available online at www.phqscreeners.com and <http://muskie.usm.maine.edu/clinicalfusion/DHHS/phq9.pdf>. Although the PHQ-9 is copyright protected by Pfizer Inc., the tools can be reproduced for clinical care and research purposes, as long as no sections of the PHQ-9 are altered or translated, the copyright statement appears on the form, and the PHQ-9 is not part of any material that is being sold (see <http://www.phqscreeners.com/terms.aspx> for the terms of use).

Anxiety

Anxiety disorders within the Marine Corps population are among the most prevalent of all mental disorders. In a recent study of over 100,000 combat-deployed and non-combat-deployed Marine Corps personnel, 3.2% had been diagnosed with some type of anxiety disorder (Larson et al., 2008). Additionally, the co-morbidity of anxiety and substance abuse disorders has been well documented in varying populations (Kendler, Gallagher, Abelson, & Kessler, 1996; Kushner, Abrams, & Borchardt, 2000; Wyman & Castle, 2006). Screening for anxiety disorders at SACCs with validated tools is essential to the recovery of Marines seeking treatment for substance abuse (Kushner et al., 2005; Marshall, 2008). Because anxiety comorbidity in substance abuse treatment patients can indicate the potential for future relapse, early identification of existing anxiety disorders can assist in selecting the most effective course of treatment (Kushner et al., 2005). We recommend the Generalized Anxiety Disorder-7 (GAD-7) for use in detecting anxiety disorders among SACC clients. The GAD-7 is a widely used, validated assessment tool for detecting Generalized Anxiety Disorders (GAD) (Spitzer, Kroenke, Williams, & Lowe, 2006; Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007). The first two items of the 7-item scale have been shown to sufficiently identify the presence of any type of anxiety disorder, while the following five items can indicate the specific type of disorder (Kroenke et al., 2007). Therefore, we recommend administering these first two items to all incoming SACC clients, and only completing the remainder of the scale if they respond positively (any response other than “not at all”) to either of them.

Total scores are calculated by adding up the response score for all seven questions. Consistent with the author's recommendations, we advise that a client with a score of 10 or higher be referred to a mental health provider for further assessment (Spitzer et al., 2006). The scale and instructions for use can be accessed online at <http://www.stokepbc.co.uk/projects/GAD-7.doc>.

Optional/Supplemental Tools

Mild Traumatic Brain Injury

Mild TBI (mTBI) among military personnel deployed to OIF/OEF is a medical issue that has been receiving increasing attention across the DoD. Assessing for mTBI at military substance abuse counseling centers is important for two reasons. First, mild traumatic brain injury can be easily missed in the warzone environment, especially if it occurs at the same time as other physical injuries (Defense Veterans Brain Injury Center, 2006). Secondly, multiple studies have found that substance abuse disorders are common among individuals with traumatic brain injury (Corrigan, Smith-Knapp, & Granger, 1998; Kreutzer, Witol, Sander, Cifu, Marwitz, & Delmonico, 1996; Corrigan, Rust, & Lamb-Hart, 1995; Kreutzer, Witol, & Marwitz, 1996). For example, Taylor, Kreutzer, Demm, & Meade (2003) found that almost 80% of subjects with TBI met criteria for an alcohol disorder. Additionally, Ommaya, Dannenberg, & Salazar (1996) found that persons with mTBI were more than twice as likely to be discharged for alcohol, drugs, or criminal convictions, compared with other military personnel discharged from the military during the same time period. Moreover, substance abuse problems have been found to significantly increase with time post-injury (Corrigan et al., 1998; Kreutzer et al., 1996; Corrigan et al., 1995; Kreutzer et al., 1996). These reasons suggest that the SACC environment is a logical and practical place to conduct this screening to identify those who may not have been previously recognized.

While the Veterans Health Administration Directive 2007-013 (Defense and Veterans Affairs, 2007) requires that all OIF and OEF veterans presenting at the Veterans Administration (VA) be screened for TBI, we recommend that this screening be used only as an optional tool for Marine Corps Substance Abuse Counseling Centers because

there is no TBI screening tool that meets all the SACC screening tool selection criteria mentioned above. Specifically, the Defense and Veterans Brain Injury Center (DVBIC) TBI screening questions used by the VA have not been validated in a controlled study (Hoge et al., 2008). Additionally, there is concern that conducting the DVBIC TBI screen months or years after a possible injury is likely to result in a large number of unnecessary referrals (Hoge et al., 2008). Despite these concerns, we recommend that substance abuse counselors who would like to screen for mTBI among their clients use the DVBIC TBI screening questions, also referred to as the Brief Traumatic Brain Injury Screen (BTBIS) developed by Schwab and colleagues (2006) (see Appendix B). The three-question tool and scoring instructions are available at <http://www.dvbic.org/pdfs/3-Question-Screening-Tool.pdf>.

Omitted Screening Tools and Rationale

Many other areas of assessment and specific measures for mental health screening have been recommended in the literature; however, they did not fit all nine of our criteria for selection and implementation at the SACCs. The three areas for screening that we have chosen not to recommend as standard across SACCs include: an expanded suicidal risk ideation assessment, trauma and life stressors, and the previously mentioned BDI. The rationale for not including these tools is explained below.

Suicidal Ideation and Plan

Although the U.S. Preventive Services Task Force (USPSTF, 2004) notes that individuals with comorbid drug or alcohol abuse disorders are at an increased risk for attempted suicide, an expanded suicide assessment is not recommended for SACC clients for many reasons. First, the Navy Clinical Package (MCO1700.24B) already includes two questions to assess suicide risk: (1) Have you ever contemplated, threatened, or attempted suicide or self-injury or injury to others? and (2) Have you ever had thoughts of hurting yourself or suicide? Secondly, item nine of the PHQ-9 (the tool recommended for depression screening) asks clients how often they have been bothered by “thoughts that

you would be better off dead or of hurting yourself in some way” over the last two weeks. Assessing suicidal risk is also part of the Post Deployment Health Assessment (PDHA) and Post Deployment Health Reassessment (PDHRA) (Wright, Adler, Bliese, & Eckford, 2008). Additionally, the USPSTF (2004) advises that there is “no evidence that screening for suicide risk reduces suicide attempts or mortality. There is limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk.” Due to insufficient information about the screening benefits for suicide ideation risk, an expanded assessment is not recommended. However, counselors should remain diligently aware that their clients are at an increased risk for suicide attempts, and should ask additional questions and follow an action plan, if needed.

Trauma and Life Stressors

A variety of trauma and life stressor assessments have been recommended in the literature about substance abuse and comorbid disorders. For example, the Iraq War Clinician Guide (National Center for Posttraumatic Stress Disorder, 2004), recommends the Life Stressors Checklist (Wolfe & Kimerling, 1997), the Trauma-Related Dissociation Scale (Carlson & Waelde, 2000) and the Traumatic Life Events Questionnaire (Kubany et al., 2000). Other recommended scales include the Stressful Life Experiences Screening (Stamm et al., 1996; Najavits, 2004) and the Trauma History Questionnaire (Green, 1996; Read et al., 2003).

While highly recommended in the literature, trauma and life stressors scales are not recommended for use in SACCs because assessing for trauma and/or life stressors does not meet the goals and needs of screening in the SACC environment. Specifically, if someone screens “high” on a trauma history assessment or life stressors checklist, it is unclear what the SACC counselor’s plan of action should be. As explained by Najavits in *Assessment of Trauma, PTSD, and Substance Use Disorder: A Practical Guide* (2004, p. 470), “Trauma itself is not a diagnosis; it is an event that may or may not still cause problems for the patient.” Although a traumatic experience of some sort is necessary for

the diagnosis of PTSD, trauma alone cannot be equated with a mental health diagnosis in the absence of other symptoms (Najavits, 2004).

Mental Health Recurrent Screening in the SACC

Research has shown that it is important to provide recurrent mental health screening for SACC clients who do not initially screen “positive,” but may be at an increased risk for mental health problems (U.S. Preventive Services Task Force, 2002; Penk, 1993).

Recurrent periodic screening is also important because, as a client’s substance use decreases, their symptoms and memories may increase, and they may no longer fall below the mental health referral guidelines (Penk, 1993). In addition, because “both PTSD and Substance Use Disorders (SUD) are highly prone to minimization, whether through lying, denial, or shame and guilt inherent in both” (Najavits, 2004), rescreening can assist the counselor in making a referral that was originally deemed unnecessary.

Although there is evidence documenting the need for recurrent mental health screening in clients with substance abuse problems, at this time there is insufficient evidence for recommending when and how often clients should be rescreened if they did not initially screen “positive.” We recommend SACC counselors use their experience and clinical judgment to make decisions about when and how often their clients need to be rescreened for mental health problems.

The Context of Mental Health Screening in the SACC Environment

Counselors need to remain aware of the many contextual factors regarding implementing mental health screening in the SACC environment. First, to accurately assess a client, the mental health assessment should not occur if a patient is intoxicated or in the early stages of withdrawal (Najavits 2004; Read et al., 2003). Secondly, SACC counselors should be aware of gender differences in mental health problems. For example, not only are depressive and anxiety disorders more common among women than men in the general population (Kessler et al., 1994), but women are also more likely

to report greater distress symptoms as compared to men (Kroenke & Spitzer, 1998; Sheridan, Mulhern, & Martine, 1999; Read et al., 2003). It is also important for SACC counselors to provide feedback to their clients about the mental health assessment, even if the reported symptoms are minor or they do not meet the criteria for referral (Najavits, 2004; Penk, 1993). As explained by Walter Penk in his article, PTSD and Substance Abuse: Clinical Assessment Considerations, “Assessment where the person being assessed does not have complete knowledge of results from the assessment is a waste of the client’s and clinician’s time” (Penk, 1993). Counselors should also remain aware that although the PCL-C is a symptom questionnaire and does not ask about any traumatic event or experience directly, screening for PTSD may increase symptoms of distress or anxiety among clients (Read et al., 2003; Najavits, 2004). SACC counselors should remain aware of this during the mental health screening process, and stop the process if a client seems to feel particularly uncomfortable or anxious. Finally, even if a client does not meet the scoring criteria specified for a referral, the SACC counselor should use their professional opinion and clinical judgment to evaluate the need for a referral depending on the client’s overall symptoms.

III. Core Principles/Lessons Learned

- All SACC sites recognize the need for client mental health screening. However, mental health screening is not yet standardized across SACC locations; the type and scope is up to each individual site.
- PTSD, depression, and anxiety are common among service members with substance use disorders.
- Substance abuse disorders are common among individuals with TBI, and a diagnosis of mTBI is often missed in the warzone environment.
- A variety of screening tools exist; however, recommendations for standardization must fit the needs and objectives of the SACC.
- Feedback to clients about mental health screening results is an important part of the process.

- There are currently no guidelines as to when and how often to rescreen clients whose initial mental health screen did not necessitate a referral, although there is evidence suggesting that this is needed.

IV. Recommendations/Future Directions

- Assess PTSD, depression, and anxiety among all SACC clients. Mild TBI is an additional optional assessment.
- Use standardized, validated screening tools appropriate for clients with substance problems from a military population. We recommend the following tools:
 - PCL-C for assessing PTSD (Weathers et al., 1994).
 - PHQ-9 for screening depression (Kroenke et al., 2003).
 - GAD-7 for screening generalized anxiety disorders (Spitzer et al., 2006).
 - DVBIC TBI Screening Tool is an option for counselors who want to screen for mTBI (<http://www.dvbic.org/pdfs/3-Question-Screening-Tool.pdf>).
- Provide feedback to clients about the results of any mental health screening—whether or not a referral is made.
- Rescreen clients whose initial mental health screen did not result in a referral; however, counselors should use their own clinical judgment to decide when and how often to rescreen.

Chapter Four

Referrals and Treatment

I. Site Summaries

Site A:

The SACC at Site A works closely with a nurse practitioner and a physician assistant at the local Branch Medical Clinic (BMC). If a SACC client shows any mental health disorder symptoms, the SACC refers them to the BMC for further evaluation. The basis for SACC referral to the BMC is subjective, and up to each counselor's discretion. While the PCL and the Marine Corps Order (MCO) 1700.24B are used to provide insight into the client's condition, no formal cutoffs are used. It is mandatory that clients follow through on mental health referrals, and the SACC counselors are notified of any clients that do not comply with this requirement. Marines are referred to an off-base mental health professional because the BMC is not currently staffed with a psychiatrist or psychologist. The BMC coordinates with local psychiatrists, psychologists, social workers, and treatment programs to arrange mental health treatment for comorbid clients. Individuals with family problems are also referred to the Family Service Center (FSC) on base. However, the FSC is known as a place to go if one "has problems," and individuals tend to avoid this center because of its reputation.

Counselors at the Site A SACC make a preliminary substance abuse (or dependence) diagnosis based on the American Psychiatric Association DSM-IV criteria. The physician assistant at the local BMC confirms this diagnosis before any SACC treatment is initiated. A Marine suffering from substance abuse (or dependence) will typically receive eight outpatient treatment sessions; followed by a written discharge summary and an aftercare plan for SACO execution. Individual treatment for substance abuse problems can include the following techniques: rational emotive therapy, systematic desensitization therapy, and the twelve-step program (focusing on steps one to four). With the guidance of the SACC counselor, a SACC client develops their own treatment plan where they make realistic drinking reduction goals. Additionally, the

counselor and client meet to discuss how the client is dealing with their drinking habits, drinking triggers and temptations, family and work environments, and other life issues. SACC treatment occurs simultaneously with any PTSD or mental health treatment a client may be receiving off base. However, SACC counselors will not provide any individual COS or PTSD counseling to a client who is receiving this type of treatment off base. Once a SACC client has completed treatment, the Site A counselors define success as continued client sobriety, and that the client is either still active-duty or did not receive a discharge due to their substance abuse problems. However, there is no formal documentation of post treatment success.

The Site A SACC also provides a voluntary COS Group that is offered to active-duty military, civilians, retirees, and reservists. The weekly support group was started because active-duty Marines are not eligible for group therapy at the VA. No specific therapy approaches are used with this group; counseling consists of group discussions that address for example: sleeping problems and fears that clients are experiencing. Any client referred out for treatment who has been diagnosed with PTSD is recommended for attendance at the COS group, but ultimately this is optional. Clients can also attend the COS group even if the BMC does not refer them to an off-base mental health practitioner.

Marines needing intensive outpatient treatment for substance abuse, mental health problems, or comorbid disorders are referred to the behavioral health center at a civilian hospital. This hospital provides a full spectrum of outpatient care through physicians, case managers, counselors, social workers, nurses, and therapists for dually-diagnosed clients.

Clients requiring residential care or inpatient treatment are referred to a civilian hospital, the closest Naval Hospital, or an inpatient unit at a nearby Army Hospital. The civilian hospital offers both partial hospitalization and residential inpatient treatment. Their residential care focuses on educating the patient about their disorder, and providing coping strategies to deal with the problem, as well as involving the patient's family in the treatment process. At the closest Naval Hospital, the outpatient treatment program is mainly focused on alcohol abuse, but psychiatrists also treat PTSD.

Site B:

Site B referred approximately 20 patients to residential treatment in 2007, and approximately 25 to intensive inpatient or outpatient treatment. Residential treatment consists of a 90-day (or three-month) program of specialized, inpatient treatment and counseling; while intensive inpatient or outpatient treatment varies in length—from four to eight weeks depending on the severity of the individual case. SACC counselors can now refer clients with possible PTSD directly to the MHU on base, without seeing a General Medical Officer (GMO) or primary care physician first. This improvement in the working relationship between the SACC and MHU has ensured that there is an open dialog regarding patient medications and other therapies that may affect the treatment of either comorbid disorder. Although many psychologists/psychiatrists at the MHU rotate frequently, so there is a need to re-establish this connection with different physicians throughout the course of an average patient's treatment. In addition, the MHU typically provides feedback to the patient's unit commander, for example recommending a light duty chit when necessary. General practitioners who see patients at routine military sick call also refer Marines who may be suffering from PTSD to the MHU.

Treatment guidelines or manuals that are followed at the Site B SACC include the NAVMC 2931, MCO P1700.24B, and SECNAVINST 5300.28C, which follow the American Association of Addiction Medicine (ASAM) guidelines and DSM-IV criteria (DON, 1999; American Psychiatric Association, 2000). In addition, there is a local Site B instruction for the SACC. Therefore, the SACC uses seven problem areas, or dimensions, of assessment for making placement decisions about which of the five levels of treatment are most appropriate for an individual client. The goal of the SACC counselor is to match the client's severity or level of functioning with the correct level of service intensity required to meet the individual's needs. The patient placement criteria grid, shown in Appendix C, is a tool that illustrates the relationships between the dimensions and treatment levels (ETP, 1998; NAVMC 2931).

Specifically, substance abuse (SA) (or dependence) treatment at the Site B SACC involves: intensive outpatient treatment that ranges from 9-20 hours/week for 4-8 weeks; 1-9 hours/week for 4-8 weeks of outpatient treatment, which includes 12-14 hours of

group/classroom psychosocial education and 3 hours of group therapy; or early intervention therapy such as 12-step support groups and instruction on ‘grounding techniques’, coping skills, values readjustment, and the *Seeking Safety* model (Najavits, 2002). The SACC promotes a social component or church-based help for those clients who express an interest, and abstinence of non-alcohol substance abuse and moderation-drinking plans (but not specifically ‘harm reduction’). Clients in outpatient treatment are also required to attend weekly local Alcoholics Anonymous (AA) meetings. These AA meetings, initially designed for Vietnam era Veterans, are held at a local veterans’ site and host a specific triple threat group for patients with PTSD, mental disorders, and substance abuse. Residential treatment is managed at a 100-bed, smoke-free Navy treatment facility; however, SACC counselors are responsible for providing an individualized, continuing after-care treatment plan for each patient upon discharge. (In addition, it was mentioned that a local Naval Medical Center uses virtual reality therapy, and other sites may use Eye Movement Desensitization and Reprocessing [EMDR] and/or pharmacotherapy.)

Treatment for clients with substance abuse (or dependence) and PTSD differs from the standard treatment provided for other SACC clients, in that the counselors use a self-directed approach. SA-PTSD treatment plans are much more client self-directed, and cannot be as SACC counselor-directed as regular SA treatment plans. In addition, the SA-PTSD specialized treatment includes both cognitive and behavioral therapies, 12-step support groups and instruction on the *Seeking Safety* model.

Recognizing that the early signs and symptoms of PTSD may not be initially present in SACC clients who were combat-deployed, treatment failure (or success) may potentially serve as an indicator or warning sign of later psychological distress. When asked how substance abuse treatment success is evaluated by SACC counselors, the Director responded with his own personal opinion of how the Marine Corps judges success, “...based on whether the Marine has another substance abuse-related offense.” He added to this statement by offering the SACC perspective about treatment success, which is dependent upon whether the client has been classified as substance dependent or a substance abuser. If the client is *dependent*, then success is based on whether or not the

client can make it through the SACC treatment program, and if he or she is an *abuser*, then success is based on whether or not the client can follow their responsible drinking plan (that is set forth in their treatment plan). According to the Director, “If they don’t reoffend they’re successful. If they don’t drink, or tell us when they do drink, they’re successful.” After treatment, approximately 10-20% of clients return to the SACC at a later time. Re-screening SACC clients for later PTSD symptom development, whether or not they are repeat offenders (i.e., repeat clients) or treatment failures, may potentially reach service members who may otherwise not seek mental health counseling on their own.

Site C:

The SACC at Site C has a large network of psychiatrists, social workers, and chaplains to which they refer clients. A SACC client that may have a psychological problem is referred to a psychologist at the clinic. In addition, if a client scores 41 or higher on the PCL-M, they are referred to the branch mental health clinic on base. In the past month, 13 out of 83 new clients (almost 16%) were referred to the MHU. In addition, about 25% of SACC clients appear to have relationship or family issues requiring referral to FAP counselors. It is mandatory for clients to utilize their referrals, and the SACC is also notified if their clients miss their scheduled referral appointments.

Treatment guidelines or manuals that are followed at the Site C SACC include ASAM criteria, NAVMC 2931, Marine Corps Order P1700.24B, and SECNAVINST 5300.28C. Individualized treatment plans are developed for clients with an alcohol diagnosis of abuse or dependence. The LIP affiliated with the Site C SACC sees all SACC clients with a possible alcohol diagnosis to confirm the diagnosis and approve the recommended treatment plan. SACC counselors and the LIP also meet weekly to summarize the week’s cases and discuss challenging aspects of client treatment. Individuals referred to the SACC, who are not diagnosed with substance abuse or dependence, are only required to attend Early Intervention treatment, a 4-hour course, and two individual meetings with their counselors. Clients with a substance abuse diagnosis attend 4-8 weeks of outpatient treatment which involves: discussion of group

and family dynamics, a video, a class with written exercises, group discussion, and individual counseling.

Clients diagnosed with comorbid substance use and psychological problems, to include PTSD, continue their SACC treatment simultaneously along with their mental health treatment. Site C counselors feel that there is a good flow of communication between the SACC and the mental health practitioners that treat their comorbid clients. Counselors are advised of the medication regime and other treatment that their clients with comorbid issues receive, and they also get a progress report that goes into each client record. Site C mental health care practitioners provide therapies that may include personal counseling, psychotherapy, and medications (pharmacotherapy). SACC treatment remains focused on substance abuse; however, counselors also discuss other issues with their comorbid clients, such as family problems. One counselor explained, “I don’t like to play psychologist; I just try to keep to the substance abuse issues.” Site C SACC counselors recommend that Marines in treatment should involve their family in the treatment and education process as much as possible.

All outpatient mental health treatment at Site C is provided at the on-base BMC. There is also a two-week outpatient treatment program provided specifically for PTSD at the closest Naval Hospital about 50 miles away. All inpatient substance abuse and mental health treatment is provided by a civilian medical provider about 100 miles away. However, due to the high number of people being referred, there is currently a 2-3 week wait time from referral to actual inpatient admission. Previously, the Site C SACC referred clients to a BMC in the next state for inpatient treatment, but there is now a 6-8 week wait. The Naval Hospital about 50 miles away also has a ‘day’ residential program from 0800-1630 everyday, but each client’s command is required to provide roundtrip, daily transportation, which is impractical.

Site C counselors define substance abuse treatment successful if a client not only meets the objectives in his/her treatment plan, but goes beyond them. “We give them the tools so they can make the changes and [maintain] them. When they realize and identify how they got to this point, they know what they need to do to stop it,” one counselor remarked. The Site C SACC expressed concern about how Marines, who were exemplary

before going to war, are now being discharged from military service for substance abuse problems. Such examples are worrisome because those negative behaviors, contrary to military life, are often due to COS symptoms, and some Marines unfortunately are either not referred to treatment or do not respond to treatment. As the LIP explained, “We have failed Sailors [or Marines] like those. We say, ‘adios,’ and [by the way] you aren’t eligible for VA benefits after all you have done.”

In addition to their concerns, the SACC staff also had a number of recommendations to share based on their collective experience. They believe that mental health problems and COS should be viewed within a medical framework because it encourages people to get treatment. “It’s a medical problem, not a character weakness,” one counselor commented. The Site C counselors also try to educate their clients about the wide network of resources available to them, and personally introduce them to other therapists and social workers that might be able to help them. As one counselor explained, “We need to give them as many resources as possible, so that if they don’t like someone or something, they will have something else to fall back on.”

Site D:

The LIP at Site D screens about 45-50 people per week for PTSD. An accurate count was not available of the actual number of patients referred outside the SACC in FY2007 or 2008; however, in FY2006, 145 clients were referred to a Navy inpatient, residential treatment facility. There were about 45 clients in intensive outpatient or outpatient treatment during the site visit, and the maximum capacity of the Site D SACC is 52 clients at any one time. Typically, the LIP refers a client to the Intensive Care Unit (ICU) at the on-base Naval Hospital, the MHU (also at the hospital), the Pre-deployment Health clinic, or to Division Psychiatry; however, the LIP also mentioned that he could refer SACC clients to a civilian rehabilitation hospital and another civilian treatment facility.

When a SACC counselor suspects a combat-deployed client is suffering from PTSD, they refer the Marine to the on-site LIP, who screens the client for PTSD and determines the appropriateness of pharmacotherapy treatment. The LIP also sees Marines

who have been referred to him based upon their responses to the PDHA Questionnaire, who may or may not also be SACC clients. The LIP at the Site D SACC has an open door policy, so that patients do not need an appointment and can have access to his services at any time. The LIP sees most patients about every two weeks while they are on medication, and that he routinely prescribes Celexa, Prozac, Zoloft, and Paxil (while only Zoloft and Paxil are FDA-approved for the treatment of PTSD). The LIP can also order MRIs to screen for TBI, and can recommend limited duty chits and Medical Review Boards for very serious cases. In general, the LIP said he feels that most commands respect his medical advice and recommendations. The LIP also mentioned how some substance abuse and/or PTSD suffering Marines may not be seen by the SACC at all, since there are other self-referral systems available (such as Military OneSource), and because some active-duty substance abusers seek treatment from civilian providers instead.

At Site D they follow the ASAM Motivational Interviewing Medical Model. Specifically, substance abuse (or dependence) intensive outpatient or outpatient treatment at the Site D SACC involves: workshops, group therapy, and individual counseling. For example, SMART Recovery, a substance abuse support group held at the base brig (jail); AA; an all men's group; and a Continuing Care Group. Evening support groups also include family and couples counseling. One specific, didactic workshop offered, called IMPACT, aims to help 'normalize' PTSD symptoms, and screen people for another PTSD process support group. Some SACC counselors use the PCL-C to screen clients, but not all are consistently following the same screening procedures. All SACC clients are required to attend IMPACT once during their treatment, and IMPACT is exclusively attended by those who have a substance use disorder. However, the PTSD group is attended by "walk-in's" who are self-referred, patients referred by the MHU, some Marines who live in the wounded warrior barracks on base, as well as those SACC clients who were screened in the IMPACT class. (The Wounded Warrior Battalion is a detachment of the local Naval Medical Center and is located in a 24-40-bed facility on base.) A social worker from the VA and a civilian psychiatrist from the MHU run the PTSD process support group once a week.

When a client is referred to the Navy inpatient, residential treatment facility, the Site D SACC location appears to be experiencing a backlog of clients awaiting admission. Previously, there was a 72-hour standard set for the maximum time period between SACC referral and in-patient admittance, but more recently there have been wait-times as long as 29 days. Currently, the wait time runs longer than 18 days because of an agreement made between Site D and the residential treatment facility. The alternatives available to avoid this excessive wait time include: 1) sending SACC clients to the on-base Naval Hospital Emergency Room, which only works for those patients needing immediate detoxification; or 2) referring clients to the hospital Internal Medicine Unit, where physicians can order an overnight admission if it is necessary to keep a patient from fleeing or to protect him or her from self-harm. These alternatives “buy time” for a day or so, during which time an immediate transfer to the residential treatment facility is arranged. The Site D SACC also faces another challenge with providing effective residential treatment for their clients due to the long distance between facilities. The facility is too far away to make command visitation of the patients in residential treatment convenient, and, as a result, command support is not usually available to those clients who are referred out.

Collaboration with other mental health professionals outside the SACC is critical, and the new electronic medical record system called AHLTA (Armed Forces Health Longitudinal Technology Application) has revolutionized their ability to effectively communicate between treatment facilities. The electronic record created for each client is supplementary to the hard copy medical record and can theoretically ‘follow’ the Marine from duty station to duty station. However, to protect the patient’s confidentiality, future military healthcare providers can only access these mental health records if they have a legitimate reason to do so at a later time. This system is extremely beneficial when clients are receiving concurrent treatment from the MHU and the SACC, or if a Marine is transferred from one duty station to another.

Treatment success is evaluated by SACC counselors by monitoring the recidivism rate. As an example, out of a total number of 2078 SA screenings conducted in 2007, 425 personnel were re-screened due to another incident or referral to the SACC. This

indicated that the Site D SACC had a treatment success rate of 80% for 2007.

Specific areas in which the SACC felt as though they needed more help or assistance included the following: 1) A local SA residential treatment facility at Site D capable of concurrently treating PTSD and SA; 2) A larger facility to locally house residential patients who need substance use disorder and/or PTSD stabilization, then step-down treatment (while maintaining the same treatment milieu); and 3) Additional LIPs so at least one psychiatrist can be solely dedicated to one SACC site to enable better continuity of care among the patients being seen for PTSD/alcohol abuse comorbidities. The Director described this further by saying that they need more consistency in the treatment being provided to their clients (once referred for PTSD).

II. Supporting Evidence/Literature

Active-duty U.S. military personnel have a variety of sources from which they can seek mental health care. Some examples include: (1) counseling is available anonymously over the telephone through Military OneSource; (2) mental health practitioners are often embedded in operational units; (3) many Medical Treatment Facilities (MTFs) have specialized MHUs; and (4) service members can also request a mental health evaluation through a referral to a civilian provider in the TriCare network (Tanielian & Jaycox, 2008). Most clinical mental health care is provided at MTFs, although mental health clinics are sometimes stand-alone facilities in locations distant from major MTFs. Treatment is typically outpatient when received from an MTF, except at locations where specialized PTSD programs have been established. Examples of such centers include the National Naval Medical Center and Walter Reed Army Medical Center. However, inpatient psychiatric care is also offered at very limited locations within the military network (Tanielian & Jaycox, 2008).

More specifically, Military OneSource is a DoD information and consultation service available to service members and their families through a confidential phone line. OneSource provides counseling for a variety of issues, including emotional, interpersonal, and adjustment problems, but was not designed to give immediate medical advice for serious mental health conditions, such as PTSD or major depression. Most

consultants working for Military OneSource have a master's degree and are licensed counselors, although some are alternatively certified as employee assistance professionals (Tanielian & Jaycox, 2008). Hence, if a service member contacts OneSource and is suffering from mental health-related symptoms; their standard protocol involves referring the caller to a network of community specialty mental health counselors for six free sessions, either in person or over the phone. However, if the caller is identified as having a severe mental health problem, OneSource counselors refer the service member to a medical care provider, such as an MTF, VA hospital, or outside civilian provider. It is important to note that none of these OneSource consultations are documented in the service member's medical record, and remain undisclosed to the military in general, unless something indicates that he or she is in danger of harming him/herself or other people (Tanielian & Jaycox, 2008).

Another mental health care resource is the cadre of multi-faith chaplains, who train and deploy alongside soldiers and Marines, and administer nonclinical counseling to nearly every military unit. Their 'ministry of presence' allows them to serve as neutral figures outside the service member's chain of command, and all discussions are held in confidence. Non-military-related, faith-based organizations in some areas also offer returning service members programs that include counseling and weekend retreats to aid in the post-deployment emotional transition (Tanielian & Jaycox, 2008). These types of resources increase access to mental health care, but service members must be self-aware, and able to recognize the signs and symptoms of COS and PTSD, to seek out these services (Tanielian & Jaycox, 2008). In addition, at the local level, each military branch has base-wide community service programs that offer short-term, confidential counseling for individuals or groups. MCCA or the Navy Fleet and Family Support Center, for example, employ civilian social workers or counselors with master's degrees; however, counseling skills and training varies at each location depending on staff experience and background. It is routine for service members presenting with PTSD, or symptoms resembling a major mental health condition to be referred to an MTF; although general counseling for less serious cases of PTSD or depression may be provided by some community service program counselors (Tanielian & Jaycox, 2008).

During the initial screening phase, counselors should make every effort to assess their clients' physical functioning and overall well-being. This is especially important for post-deployment returning service members whose sleep, appetite, energy level, and concentration may still be disrupted by their recent traumatizing experiences. The *Iraq War Clinician Guide* specifically recommends referring clients showing PTSD symptoms for a complete psychological examination, which will help with planning the appropriate interdisciplinary treatment for comorbid suffering clients (National Center for Posttraumatic Stress Disorder, 2004). Research on PTSD and substance abuse comorbidity often discusses the usefulness of determining which disorder is primary, or using the temporal order of disease development to facilitate treatment planning (Read et al., 2003). However, in many cases, this process can be challenging, and it may not be possible to discern the primacy of one disorder over the other. This is due to a broad spectrum of, "emotional and cognitive responses to deployment and post-deployment stressors including fear and anxiety, sadness and grief, anger or rage, guilt, shame and disgust, ruminations and intrusive thoughts about past experiences, and worries and fears about future functioning may be expected" (National Center for Posttraumatic Stress Disorder, 2004). There is also some established evidence that suggests that the relationship between PTSD and substance abuse is more symbiotic than causal or temporal (Read et al., 2003). As a result, counselors should keep in mind that while the temporality of a client's comorbid disorders may provide additional insight into the pathology of their diseases, it should not outweigh the current clinical picture of symptoms affecting their client. In their book entitled, *Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders*, Read et al. (2003) recommend assessing symptom severity to first address a client's most acute, severe, or debilitating symptoms. For example, first controlling a client's anxiety level will improve their odds of successful alcohol abuse treatment (Friedman, 1993). Thus, symptom severity may be a better indicator of immediate treatment needs, and how to best go about simultaneously treating both PTSD and substance abuse.

The Iraq War Clinician Guide goes to great lengths to educate clinicians and other health care providers about the military frame of mind their patients operate under, "Individuals join the military for a variety of reasons, from noble to mundane.

Regardless, over time, soldiers develop a belief system (schema) about themselves, their role in the military and the military culture. War can be traumatizing not only because of specific terrorizing or grotesque war-zone experiences but also due to dashed or painfully shattered expectations and beliefs about perceived coping capacities, military identity, and so forth” (National Center for Posttraumatic Stress Disorder, 2004). It is critical that all counselors gain an appreciation for the stressors of war, which have a profound and lasting effect, and that they understand how any form of early intervention or mental health treatment involves “providing experiences and new knowledge so that accommodation of a new set of ideas about [themselves and] the future can occur” (National Center for Posttraumatic Stress Disorder, 2004). One strong, negative predictor of mental health treatment outcomes that has been well documented is the presence of substance abuse before, during, or after SA treatment (Boudewyns, Woods, Hyer, & Albrecht, 1991). Consequently, self-efficacy, readiness to change, and motivation to receive treatment should be fundamental to any treatment program, but only after demanding strict adherence to a substance abuse abstinence agreement (Hyer, McCranie, & Peralme, 1993). Probing into a client’s perceptions of the mental health symptoms he or she is experiencing, and whether or not he or she feels that they are related to substance use can reveal important information about a client’s symptom constellation, and may be useful in addressing a client’s willingness to change (Saladin, Brady, Dansky, & Kilpatrick, 1995). One study conducted by Brown, Stout, and Gannon-Rowley (1998) clearly illustrated this concept by documenting a positive relationship between SA-PTSD patients’ perceived connection between the simultaneous symptom improvement (or worsening) of their substance abuse and PTSD disorders. These findings indicate that knowledge of the association between worsening PTSD symptoms and continued substance abuse has the potential to positively influence a client’s willingness to actively participate in his/her own treatment.

The first integrated treatment available for both substance abuse and PTSD with positive outcome results in publication was known as the *Principles of Seeking Safety*. *Seeking Safety* is based on five central ideas, “(1) safety as the priority of this first-stage treatment; (2) integrated treatment of PTSD and substance abuse; (3) a focus on ideals; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5)

attention to therapist processes” (Najavits, 2002). *Seeking Safety* was created for substance abuse and dependence disorders, and for both individual and group counseling environments. Comprised of 25 topic areas, including cognitive, behavioral, and interpersonal subject matter, *Seeking Safety* aims to provide safe coping skills for enabling clients to maintain their own safety from substance abuse and PTSD (Najavits, 2002). It is imperative for all stakeholders involved in SA-PTSD comorbid treatment to recognize how the PTSD assessment process alone may reactivate traumatic memories and trauma-related symptoms, which may then result in urges to use substances as a familiar coping mechanism (Read et al., 2003). Mental health care providers should explain this potential increase in symptoms caused by PTSD assessment, and substance abuse counselors should work with comorbid clients to develop strategies for countering impulses that may trigger substance abuse. Group therapy is also a very important format for SA-PTSD comorbid treatment because it fosters a social support network for giving and receiving moral support from others experiencing similar symptoms. One VA physician concluded, “A critical factor is encouraging patients to seek social support and maintain it because once they leave the program they are vulnerable to isolation again” (Aboytes, 1993).

PTSD treatment programs that use evidence-based interventions have been proven effective—resulting in complete remission among 30-50% of PTSD cases, and modest improvement among the remaining 50-70% (Friedman, 2006). Likewise, substance abuse treatment programs, specifically SACC counseling and therapy, documented an 80% treatment success rate. However, often treatments that are effective for PTSD or SA independently may not have the same desirable affect when used with comorbid patients. “For example, PTSD treatments such as benzodiazepines or exposure therapy may not be indicated if a patient is addicted to substances; substance abuse treatment such as twelve-step groups may not work when a patient has PTSD” (Ruzek et al., 1998; Satel, Becker, & Dan, 1993; Solomon, Gerrity, & Muff, 1992). In addition, research suggests that recovery from substance abuse disorders is more challenging for those patients also suffering from PTSD. Therefore, PTSD and substance abuse disorders should not only be addressed through integrated treatment, but relapse prevention programming should also focus on maintaining client skills for coping with traumatic

stress symptoms without alcohol or drugs. Skills-based relapse prevention that teaches drinking refusal skills, methods to circumvent social drinking behaviors before abuse occurs, and role-playing to rehearse real-life situations is recommended for comorbid clients in recovery (Aboytes, 1993).

III. Core Principles/Lessons Learned

- Criteria for referral vary by SACC; however, most utilize their LIP to confirm a mental health diagnosis before referring clients to a wide range of mental health treatment providers/facilities (military, civilian; locally on-base or off-base).
- Overall, substance abuse treatment levels are relatively standardized across SACCs, but include different types of psychosocial education, therapy, and support groups.
- Transferring a client into residential treatment and maintaining command and family support networks are challenging for most SACCs.
- In general, post-treatment success is evaluated differently, and there is no formal documentation of post-treatment success at the SACCs.
- Treatment guidelines followed by most SACCs include the NAVMC 2931, MCO P1700.24B, and SECNAVINST 5300.28C, which follow ASAM guidelines and DSM-IV criteria.

IV. Recommendations/Future Directions

- Develop and maintain a comprehensive list of mental health care referral points of contact, with the provider/facility treatment practices and areas of expertise, for treatment plan development and case management.
- Research suggests that a simultaneous treatment approach will be most effective in helping SACC clients with comorbidities; Promote the Principles of *Seeking Safety* model (Najavits, 2002), which focuses on safety, integrated

SA-PTSD treatment, and case management. Also encourage Marines in treatment to involve their families in the treatment and education process as much as possible.

- Collaborate with USMC Headquarters to contract additional residential treatment facilities that are capable of concurrently treating SA-PTSD, have shorter admission wait times, and are more conveniently located for SACCs and the commands that they service. Explore on-base locations (unused barracks for example), and develop a local residential substance abuse treatment program to allow for more frequent command and SACO contact with the client.
- Define substance abuse post-treatment success (or failure) in a standardized way, and create specific plans of action for reassessing PTSD and SA among Marines who return to the SACC for additional treatment.
- Adapt current treatment programs to specifically address comorbid issues, and incorporate step-down SA-PTSD treatment concepts to help maintain the same treatment milieu throughout a client's recovery process.

Chapter Five

Case Management and SACO Coordination

I. Site Summaries

Site A:

At Site A, all clients that are referred from the SACC to the base branch medical clinic and then off-base for PTSD treatment must be followed-up by a nurse practitioner. Due to the lack of a mental health specialty on base, clients are usually referred outside the military health system provider network. A physician assistant from the medical clinic makes all PTSD diagnoses and referrals, and usually notifies the SACC about which patients were actually referred out for treatment. A nurse practitioner, who works at the branch medical clinic, handles all case management for clients suffering from mental health problems, including PTSD. However, there doesn't appear to be a clear system of ensuring that those patients, who also have substance abuse problems, return to the SACC for substance abuse counseling and treatment for their comorbid disorder. The nurse practitioner tracks the attendance of Marine clients, and the type of PTSD therapy and medications that are provided by the off-base mental health providers. For example, some treatments include cognitive therapy, EMDR, and pharmacotherapy. A client's substance abuse treatment typically occurs concurrently with their PTSD therapy, but the counselor at Site A said that he will not discuss a client's PTSD problems during substance abuse treatment sessions if the client has already been referred off-base.

The nurse practitioner and the physician assistant discussed the need for additional guidance regarding the 'Fitness for Duty' screening that is ordered several months after a comorbid SA-PTSD diagnosis has been made if the Marine is not responding to treatment. Apparently, this screening occurs at the inpatient facility at the nearest Naval Hospital, but there is little guidance about when to refer a client to the hospital for the "Fitness for Duty" evaluation. In addition, the Senior Medical Officer at the medical clinic mentioned how there should also be more official guidance concerning transferring Marine clients (to a new duty station) in the middle of their PTSD treatment.

He said that maintaining continuity of care is extremely difficult when clients are deployed or transferred soon after a PTSD diagnosis has been made.

Aftercare treatment at Site A is a year-long, monthly follow-up process that is carried out by unit SACOs after the completion of all SACC treatment programs. Although the counselor personally conducts the 8-12 weeks of “continued treatment” after a client has completed the 28-day-long, inpatient, residential treatment, the SACO typically provides encouragement to SACC clients and ensures that they are continuing to attend SACC classes. If another alcohol-related issue or incident occurs, then the SACO refers the Marine back to the SACC for additional treatment. One of the unit SACOs at Site A pointed out that the MCO P1700.24B states, “Any Marine who returns to the abuse of alcohol and/or whose standards of conduct and performance declines following the successful completion of a treatment/aftercare program will be processed for separation [from the Marine Corps] ... if determined not amenable or qualified for additional treatment.” If the Marine is deployed or transferred, the SACO is then supposed to notify the receiving command’s unit SACO and Non-commissioned Officer in Charge of the Marine’s current aftercare program status. The SACC does not confirm that the SACO has effectively carried out the year-long aftercare plan; however, counselors feel that there needs to be more coordination between the SACC and the SACO. Often, there is very little communication between the SACO and the SACC post-SACC treatment, unless a Marine has another incident and is deemed a “treatment failure.”

Site B:

At Site B, the SACC handles the majority of case management work. Counselors must ask for a copy of the report that is written up by the psychologists whom their clients were referred to, and then they can follow-up with each client. Some clinicians are restricted by HIPAA laws, and this contributes to weakening communication between the SACC and other mental health practitioners. However, there is a rudimentary follow-up system in place to track patients throughout the course of their treatment—both within the SACC and when they are referred other medical providers. While seeing the

psychiatrist/psychologist that Marines have been referred to is ‘technically’ required, the Navy is less restrictive about following up on referrals. Since every service member’s medical record is self-maintained, even though it should be reviewed by a physician at their Pre-Deployment Health Assessment, any record of a mental health referral could have been removed (for example, by the Marine client). A client’s substance abuse treatment is usually conducted simultaneously with their PTSD or any other mental health therapy that they may be receiving. For example, some SACC clients see the MHU clinicians 1-2 times per week. In addition, each client typically has a one-year long aftercare plan that is supposed to be executed by the client’s unit SACO. The SACC is not routinely involved in verifying the aftercare plan was completed, unless there is a problem or a Marine is involved in another alcohol-related incident that causes them to be sent back to the SACC for additional treatment. According to the SACC Director, the best way to develop a collaborative working relationship with key mental health professional stakeholders in the area should involve seeking outside referrals to the VA, county civilian mental health providers, and local AA groups. One of the SACC counselors at Site B agreed by saying, “Each place [SACC] is going to have to develop their own relationship with mental health providers [in their area].”

Site C:

From the SACC’s perspective at Site C, case management, or a formal system of follow-up, is very difficult to maintain due to personnel movements and transitions. Continuity of care is a big problem, and there is little documentation of mental health treatment. If a client is receiving treatment at the SACC on an outpatient basis, he or she can be transferred to a different unit or duty station (and this happens frequently). When asked to describe the current system of follow-up, counselors explained that the SACC writes a post-treatment letter to each client’s unit commander and unit SACO providing recommendations for an individualized aftercare treatment plan. The SACO is then supposed to carry out one full year of aftercare by having biweekly meetings with the Marine client. The MCO P1700.24B instruction also states that clients should participate in self-help groups, such as AA, during that year of aftercare, but the Site C SACC

counselors feel that this policy is outdated. However, Marines involved in aviation are supposed to be monitored more closely. Counselors feel that continuity of care is an issue regarding SACO aftercare. SACOs have a high turnover rate, and not enough information gets passed from outgoing to new incoming SACOs. Some units do not have a SACO at all, while other units have a full-time civilian SACO (for example, like one very large unit at Site C [the Headquarters and Headquarters Squadron: H&HS unit) that has 1500 Marines]. SACOs need more training on how to provide the appropriate aftercare, and more of the SACO training needs to focus on client management (for example, three days out the 7-day course).

From the unit SACO perspective, many Marines in aftercare see the biweekly meetings, which only last about 15-20 minutes, as an inconvenience to them. Typically SACOs don't ask directly about their drinking habits. They first ask about their family and kids, after which the discussion turns to drinking and other issues. The SACOs interviewed feel that the administrative part of their job is easy and that they get good feedback on this, but, "We lack client management [skills]. We should have at least three days of training on this." SACOs would also like additional training on current alcohol and PTSD comorbidity issues, and feel as though their billets should be longer term (one or two years in length). They feel that when talking with their clients, "...things come out and you have to be a counselor. We're not trained for that." They would like more information on PTSD identification, warning signs, and extra screening questions that they should ask clients to evaluate their mental health status. "The 2-day class doesn't give you everything you need. You need at least a week."

Site D:

The Site D SACC Director concurred with the sentiments of the Site B SACC when discussing case management; he said, "Case management is SACC driven, but we use AHLTA [the electronic medical record] to track referrals." He specifically recommended using AHLTA at all SACCs, where it is logistically feasible, because it has greatly improved their ability to conduct efficient case management. In addition, the Director mentioned that patients are reevaluated every time they come to the SACC for

treatment (i.e., case management is internal too, which means that clients can be re-diagnosed and their treatment can change.) The SACC Directors from Site D and Site B also agreed regarding the questionable completion of the 1-year aftercare plan that is supposed to be executed by the client's unit SACO. SACOs are also supposed to submit a report about the initial alcohol-related incident that triggered the client's SACC screening; however, this report is not always timely, sometimes is not completed at all, or the client may be self-referred (in which case the SACC has no background information to go on at all). The SACC Director at Site D tried to put the situation in perspective by emphasizing the fact that this site has approximately 30-40,000 personnel divided among 70 commands, which means that their SACC works with 70 different SACOs who turn over about every six months. As a result, the SACC does not routinely verify that each client's aftercare plan is completed with their respective SACO.

II. Supporting Evidence/Literature

The Marine Corps Personal Services Manual clearly states that case management is an essential component in the recovery of Marines who require treatment at SACCs (DON, 2001). This is even more imperative for clients with a dual diagnosis, substance abuse and PTSD for example, because they usually receive services from multiple agencies or treatment facilities. The instruction directs the SACC director to "ensure patients receive all services necessary to address their individualized needs using case management." The nonprofit RAND Corporation published a research report in 2008 that provided objective analysis of the psychological and cognitive injuries of combat called, *Invisible Wounds of War* (Tanielian & Jaycox, 2008). The RAND report specifically addresses how case management can lead to better coordinated services and improved comprehensive care. Currently, due to the confidentiality of base counseling records and the complications that arise from having different forms, databases, and standard operating procedures at each separate DoD medical department and counseling center, tracking a patient's treatment can be a time-consuming task for medical providers and counselors. Base counseling centers do refer clients to DoD MTFs; however, "the extent to which the MTFs and counseling centers otherwise interact or coordinate care

reportedly varies from extensive to highly infrequent,” (Russell, 2007; Tanielian & Jaycox, 2008). A system of co-management and case management was proposed by the VA Task Force on Returning Global War on Terror Heroes, which involved assigning a primary case manager for all active-duty service members who receive care at both DoD and VA facilities concurrently (Tanielian & Jaycox, 2008). This case management concept can certainly achieve the same goal of increased coordination and smoother transitions between multiple service providers within the Marine Corps Substance Abuse Program as well.

Case management should provide each Marine client more continuity by offering a single point of contact for those receiving health services from multiple facilities. Case management is grounded in a counselor’s understanding of the client’s experiences, the nature of substance addiction, and the complexity that mental disorders add to the problems they are facing (HHS, 1998). The counselor should gain an appreciation of the Marine client’s belief systems (or schema) that they have developed about themselves and their role in the Marine Corps, and then try to uncover the difficulties that each Marine is having assimilating his or her past war-time experiences into that individual’s existing schema (National Center for Posttraumatic Stress Disorder, 2004). Case management requires an ability to comprehend the natural course of addiction and recovery, to anticipate mental health problems, to be knowledgeable about the available options to manage them, and to take the appropriate action to assist the client in receiving the most effective treatment (HHS, 1998). “It will be important for us to broadly assess functioning over a variety of domains, to provide referrals for acute needs, and to provide some normalizing, psycho educational information to [Marines] and their families in an attempt to facilitate existing support networks and [the] naturally occurring healing process” (National Center for Posttraumatic Stress Disorder, 2004). The case manager must be able to mobilize needed resources, which often requires negotiating formal medical care systems, and “bartering” informally among other types of civilian service providers (HHS, 1998).

Case management also involves patient advocacy and the need to promote the best interest of the client. This may sometimes involve bargaining with other agencies on

behalf of a client to gain access or to continue therapy, for example when arranging inpatient, residential treatment (HHS, 1998). “Patients with a substance abuse-PTSD dual diagnosis may have intensive case management needs, which may go beyond the training of some clinicians [or counselors] and sometimes lead to ‘burnout’” (Najavits, Shaw, & Weiss, 1996a; Najavits, 2002). This is why it is critical that case managers understand the value of an interdisciplinary approach to addiction treatment, and that every effort is made to follow-up on referrals by communicating between both SACC staff and the mental health practitioners providing medical treatment simultaneously. “The need for cross-training is common: The cultures, assumptions, and treatments for substance abuse and PTSD can be quite different, and most therapists do not have equal expertise in both,” (Evans & Sullivan, 1995; Najavits et al., 1996b). It is also important to recognize the differences that may arise from service coordination between facilities whose treatment approaches may be based on different assumptions (HHS, 1998). In addition, some working knowledge of the benefits, side-effects, and drug interactions of commonly prescribed medications for PTSD (and other mental disorders, such as anxiety or depression) is needed to appropriately manage the symptoms and behaviors of comorbid suffering clients (HHS, 1998). It is not necessary for case managers to be subject matter experts in mental health disorder treatment; however, it is critical that they possess enough knowledge to assess a client’s needs and to then facilitate the appropriate treatment to meet those needs.

The Marine Corps Personnel Services Manual also dictates that, “a Substance Abuse Control Officer (SACO) will be appointed in writing for at least one year to assist in satisfying the requirements of the unit prevention program” (DON, 2001). The manual further describes the responsibility of the SACO to include maintaining case files on Marines who have substance abuse problems, and providing aftercare services for those who complete SACC substance abuse treatment programs. Specifically, SACOs are responsible for, “Identify[ing], evaluat[ing], counsel[ing], and recommend[ing] the referral of drug/alcohol abusers to the Substance Abuse Counseling Center” (DON, 2001). Aftercare occurs at the unit level, not at the SACC, although the SACC must prepare an aftercare plan for the unit SACO to execute. Aftercare requires close observation and at least biweekly meetings between the SACO and the Marine client for

a period of 12 months post-treatment. Research shows that aftercare tends to be long-term for clients suffering from mental illness, as well as substance abuse, due to medication adherence problems that sometimes lead to substance abuse relapse (HHS, 1998). According to the manual, SACOs are “responsible for monitoring Marines in the aftercare program and providing an accurate assessment of their progress to the Commanding Officer [of their respective units]” (DON, 2001). Per the Marine Corps Order, the only time the SACO is required to communicate with the SACC is when a Marine in aftercare encounters difficulty adhering to the aftercare plan. The SAMSHA suggests, “If different individuals perform case management and addictions counseling, they must communicate constantly during aftercare about the implementation and progress of all service plans.” Moreover, based on the model of case management proposed by the VA Task Force on Returning Global War on Terror Heroes, it seems likely that the most effective method would involve continuous communication between the SACC and the SACO (Tanielian & Jaycox, 2008).

Other challenges affecting access and continuity of care include: frequent changes in health care providers, seeking outside civilian services, and the negative stigma associated with mental illness. The nature of military service involves periodic duty station relocations that cause service members to change their health care providers more routinely than the average civilian. These transitions pose particularly difficult tests of the mental health care continuum, especially when treatment started at one facility or location is interrupted and needs to be continued at another location providing DoD health care (Tanielian & Jaycox, 2008). Many service members are overwhelmed by the task of navigating a new installation’s patient care system, and, as a result, some will fail to reinstate treatment altogether. Clinicians at their new duty station may also lack access to the appropriate documentation of prior mental health consultations for their new patients. To combat this challenge, the DoD Mental Health Task Force recommended that each Military Service write new “hand-off” policies—dictating clear responsibilities and methods that should be carried out by mental health professionals at both the losing and gaining installations (DoD Task Force on Mental Health, 2007b; Tanielian & Jaycox, 2008). Routine or short-notice deployments also pose a similar threat to the stability of a service member’s mental health treatment, and require considerable coordination between

healthcare providers at multiple locations world-wide. One SACC location specifically recommended creating additional guidance requiring a pre-deployment ‘psychological clearance’ for those service members who have already been diagnosed with PTSD (and possibly comorbid substance abuse, as often is the case). The newly employed AHLTA, or electronic medical record, was “intended to create a ‘seamless visibility’ of health care information across the DoD medical system” (McKaughan, 2007; Tanielian & Jaycox, 2008). This electronic system has greatly improved communication between DoD medical facilities, and has decreased the time and resources required to maintain effective case management. However, AHLTA is not currently available at all SACC locations.

The DoD’s consolidated resource and referral project, Military OneSource, offers military members and their families branch-specific information, advice, and referrals through on-line and telephone counselors at no cost (<http://www.militaryonesource.com>). While this is an unparalleled, ‘one-stop-shopping’ resource, the civilian medical providers that OneSource consultants often give referrals to pose another unique challenge to continuity of care. These community-based services have no formal communication pathways or shared medical record systems with the military healthcare network. OneSource master’s level consultants are trained to offer confidential support, and receive specialized training on military culture, PTSD, and TBI in an effort to address this problem and align their referrals to local MTFs or the standard TriCare civilian network (Tanielian & Jaycox, 2008). Likewise, some military service members choose to pay for community-provided mental health treatment “out-of-pocket” to limit their exposure to the negative stigma associated with on-base mental health care. Increased active outreach by the DoD and VA—aimed at educating service members about the services provided within the military medicine system—could improve access to care, “However, the negative attitudes within the military culture associated with having and treating a mental disorder are a major barrier to care that must be addressed system wide” (DoD Task Force on Mental Health, 2007a; Tanielian & Jaycox, 2008).

III. Core Principles/Lessons Learned

- A system of case management applied to clients with comorbidities can lead

to improved comprehensive care, better coordination, and smoother transitions between multiple medical service providers.

- When different individuals or medical treatment facilities perform case management and substance abuse counseling, continual, open dialog and coordination throughout the aftercare process is in the best interest of the client.
- Unit SACOs do not receive sufficient client management training, and need additional training on problems involving the comorbidity of alcohol abuse and PTSD symptoms.
- To more successfully manage client transfers and deployments, the DoD Mental Health Task Force recommended that each Military Service clearly delineate—in writing—“hand-off” policies for mental health professionals to follow at both the losing and gaining installations involved.
- The AHLTA electronic medical record system has greatly enhanced the ability of DoD medical departments to communicate, as well as decreased the time and resources required to maintain effective case management.
- Military OneSource often provides referrals to civilian, community-based medical providers, which poses a unique challenge to continuity of care because these services have no formal communication or shared record systems with the military healthcare network.
- Military culture has bred a negative attitude towards seeking mental health treatment, which has resulted in a barrier to health care and some service members paying “out-of-pocket” for community-provided services.

IV. Recommendations/Future Directions

- Initiate more proactive case management practices, beginning at the SACC counselor level and following a client all the way through substance abuse aftercare and psychological referral. Designate one dedicated case manager at

each SACC, if staffing allows, or ensure that each counselor fulfills the case management role.

- Increase communication between SACC counselors and unit SACOs, to include monthly updates on the status of aftercare plan adherence throughout the one-year follow-up period. Ensure SACOs provide an adequate “turn-over” to their relief, especially when this occurs more frequently than the required 1-year SACO tour.
- Improve unit SACO training to incorporate client management skills training, information on PTSD identification, warning signs, and mental health status screening questions.
- Create local standard operating procedures at each SACC to address “hand off” procedures for effectively managing client transfers and deployments.
- Expand coverage of the AHLTA system to include computer terminals or workstations at each SACC. To include providing the necessary infrastructure, computer equipment, and staff training.
- Coordinate with Military OneSource to facilitate referrals to a SACC in the anonymous “caller’s” location by providing the organization/contractor with a comprehensive list of SACC locations and substance abuse inpatient treatment facilities.
- Reduce the barrier to mental health care by educating and engaging USMC leadership (“from the top down”) in the fight to dissolve stigma and negative attitudes surrounding PTSD, COS, and mental health treatment. Additionally, implement organizational command-level training that can be self-disseminated down to the unit level to further combat this barrier.

Chapter Six

Client Education and Information

I. Site Summaries

Client education and information is an important part of the healing process for substance abuse clients, regardless of whether they have comorbid psychological conditions related to combat or wartime operations. By providing information to clients who present for substance abuse, and PTSD in particular, counselors are in a unique position to encourage clients to recognize, solicit help, or otherwise deal with potential problems at a stage when they may not be ready to reveal them to anyone. In looking at client education and information in SACC facilities, a two-tiered examination is required. First, what general materials are available or provided to SACC clients, and secondly, which of those materials are specifically targeted at PTSD or COS.

The information provided at the SACCs that we sampled was varied. There was no consistent resource that was used at each center. Within the context of standard substance abuse related materials provided to SACC clients in general, the *Addiction Treatment Planner*—from which handouts and education materials are generated at Site B, and the *Living in Balance* workbook—from which materials are generated at Site D, both address PTSD and related disorders on some level. The *Addiction Treatment Planner* is considered standard guide to writing treatment plans for substance abuse clients. It addresses psychological issues including PTSD, anxiety, grief and loss, depression, anger, and other issues that might be ubiquitous in SACC clients. Similarly, *Living in Balance* is a 12-step based client workbook with 12 core assignments designed to direct substance abuse counseling sessions. Among the areas covered are triggers to substance use, stress, anger, communication, and emotions, all of which may have some intensified interaction for those with a comorbid psychological condition. While it is not certain that the supplemental guide to *Living in Balance* is used at Site D, it does include grief and loss, along with their relationship with addiction, which would also be significant for those with combat related problems. While no such specific take home

materials for SACC clients were noted by counselors at Site A and Site C, it is possible that they, too, provide general substance-related materials that may have some potential benefit to those also suffering from PTSD.

Within the context of materials targeted at those who potentially have PTSD or other stress disorders, a wide range of materials was also found at the different bases. All the sites have some type of pamphlet or handout that discusses PTSD, and several have posters with PTSD-related themes in their client waiting areas. At Site C, their collocation with the family counseling center made materials and individual counselors with expertise in PTSD extremely accessible. A subset of their available materials beyond standard pamphlets¹ included a pocket guide (*The Quick Series Guide to PTSD*) and a DVD (*Recognizing Combat Stress*) on PTSD that is aired on the local affiliate of Armed Forces Network (AFN). While this is not necessarily a type of material that can be distributed like a paper handout, it is a critical component of their client (and potential client) information campaign. At Site A, where the SACC conducts a regular workshop with those suffering from combat related stress disorders, specific client education material comes from *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms*. This workbook is designed to be used by sufferers of trauma rather than the counselors, and is structured as a guide that helps readers learn effective ways of dealing with the trauma they have experienced. Exercises are designed to initially begin working with the most severe symptoms and then gradually work on those of lesser severity as their treatment progresses.

What is clear and consistent across all sites is that counselors would like to have additional materials to provide for their clients, and particularly those that address the stigma associated with seeking help for PTSD. The DVD used at Site C to some degree serves this purpose, as do some of the brochures, but little material is available with stigma as the central focus. Material that addresses stigma and provides healthy coping strategies may have crucial implications for those Marines who are averse to seeking treatment. Such material can enhance the client information and resources that currently exist at all of the SACC sites.

II. Supporting Evidence/Literature

Patient education is a critical component of providing information to help with treatment in a variety of settings. In the substance abuse setting it can help with adherence to treatment plans, understanding substance abuse, and how to seek additional assistance. When dealing with comorbid disorders, particularly those associated with stigma, education and information materials can help clients understand their condition. Individuals with substance abuse disorder and PTSD frequently have poorer psychological, physical and social health than those individuals with either disorder alone (Cook, Walser, Kane, Ruzek, & Woody, 2006). These individuals also use more costly inpatient services, tend to have more relapses and are less likely to complete treatment. Patient information is essential to educating patients about how simultaneous treatment of their PTSD and substance abuse can lead to a more successful recovery (Najavits, 2007).

The majority of the literature on patient/client educational materials focuses on the medical or clinic setting (Henry, 1998). There is a dearth of published material focusing on the effectiveness of patient information materials. Informational brochures are available for nearly every condition found in medicine or psychology, and substance abuse and PTSD are no exception. They are nearly a staple for basic information on any condition. The literature focuses on readability and client understanding (Brownson, 1998; Maynard, 1999), which are made more difficult the more complex the presenting condition is. No differentiation is made in the sparse available literature between those meant to describe the condition, provide resources for treatment, or reduce stigma related to a medical condition.

The brochures used at the SACCs all appear to be readable and properly tailored for their targeted population. The materials raise awareness to the patients and their family members. The materials consist of DVDs and brochures to help provide awareness on the signs and symptoms of PTSD and COS. There are quick guides for military personnel and their families that provide information on explaining PTSD, coping strategies, stress management, treating PTSD, and a list of important resources. The materials also emphasize that PTSD is not a sign of weakness and provide resources on where to get additional information.

The benefits of patient education in enhancing treatment are considerable. Individuals suffering from PTSD are likely to develop coping strategies, which may maintain or intensify their difficulties. The lack of clarity and understanding of the trauma can certainly perpetuate the disorder. Attempts to implement trauma-focused therapies may result in high dropout rates if clients are not educated about the disorder. Hence, exposing patients to educational interventions have been shown to increase knowledge about their conditions (Gray, Elhai, & Frueh, 2004). Educational information has also shown to significantly help the treatment process in combination with mental health services. (Gray et al., 2004). Additionally, clients in a SACC setting, who are not yet ready to admit that they feel they may be suffering symptoms of PTSD or COS, might be willing to take client information materials—such as brochures—home to find out more about the conditions.

Gray et al. (2004) instituted an eight week PTSD patient education and orientation program for 17 patients at a large VA hospital to emphasize the importance of patient education on treatment. Researchers found that satisfaction with the patient education group and symptom benefits as a result of attending the group were quite strong; many veterans did perceive an improvement in symptoms by attending the educational program. Most importantly participants strongly agreed that they were more likely to continue with the PTSD treatment because of the educational services. Frueh et al. (2004) also indicated that patient education is important to ensure that the patient has a realistic understanding about the treatment prognosis.

There are many more opportunities for mental health clinicians to provide additional information to patients regarding their disorders. Mental health clinicians may not be aware that there is an extraordinary amount of material on SUD and treatment that can be obtained free from the government, either downloaded from the internet or by phone (Najavits, 2004). Clients often have little or no information or knowledge about their PTSD and its relation to SUD (whether through denial or lack of awareness of the meaning of their symptoms), even though they have lived with the illness for many years. Najavits (2002) indicated that it is often therapeutic to learn about PTSD and

comorbidities. Psycho education can help clients move toward awareness of their symptoms, rather than perceiving themselves as “crazy, lazy, or bad.”

Treatment-Related Handouts and Worksheets

In addition to the standard brochures and handouts, there are treatment-related handouts and information materials that are used at several sites. These are different from informational handouts and brochures in that they tend to have an interactive component for the client to work on or think about. Some counselors use them during group sessions, and some refer to them as “homework”, giving them to their clients and discussing them upon their return. As previously mentioned, Site A uses specific client education materials from *The PTSD Workbook* during sessions to help clients deal with their COS-related issues. This book in particular was designed to be a patient education tool for individual use. The resource features consist of treatment plan components for behaviorally based problems; a step-by-step guide to writing and following treatment plans; and documented prewritten treatment goals, objectives, and interventions; and a workbook format with space to record treatment plan options.

Similarly, the *Marine Corps Substance Abuse Workbook* used at Site B has worksheets that are used to help clients understand their substance use behaviors, factors that serve as triggers to abuse, and how to cope. The sections include: an introduction to client’s situation; exercises on abuse vs. addiction; family structure and functioning; life management, self-help options, taking action, and information on relapse prevention. As mentioned earlier, Site C also uses a guide for military personnel and their families listing information on the explanation of PTSD, symptoms of PTSD, stress reaction to war, coping strategies, stress management, treating PTSD, and a list of important resources. The use of educational worksheets in treatment may help clients with reinforcing and retaining skills that they learn.

Web-based material

Web-based materials are also an expanding form of client education and

information materials. The sites that were visited for this report use Web-based resources to some degree or another, whether it is to provide a site for downloading and viewing other materials (Site D), or to link to additional resources (e.g. Site C's Combat Stress Video). A resource that is commonly used in the assessment process is militarymentalhealth.org. This site will provide information on whether or not a patient has symptoms that are consistent with a condition or concern that would benefit from further evaluation or treatment. Another resource that several sites direct patients to is OneSource, a link targeted at assisting military personnel with confidential help for a variety of issues.

As previously noted, Gray et al. (2004) indicated that educational information has shown to significantly help the treatment process in combination with mental health services. Many of the visited sites create this combination of services in their client information packages. Site C offers a list of Web-based links for clients to learn more information about PTSD and substance abuse. International Critical Incident Stress Foundation (www.icisf.org) is a non-profit organizational which presents education on crisis intervention, stress, and PTSD. This Web site is provided to patients as it includes helpful articles on their current condition. The National Center for Posttraumatic Stress Disorder (www.ncptsd.va.gov/ncmain/index.jsp) provides many useful resources for veterans on the issue of PTSD. The Department of Veterans Affairs and Department of Defense Posttraumatic Stress Guideline (www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm), is seen by many as an educational tool similar to textbooks and journals, but in a more user friendly format. Another educational resource is Substance Abuse and Mental Health Services Administration (www.samhsa.gov). This Web site provides a broad collection of helpful articles on many topics including traumatic stress. The National Institute of Mental Health (www.nimh.nih.gov) is the largest scientific organization in the world dedicated to research focused on the understanding, treatment, and prevention of mental disorders. In addition, there are also resources to assist loved ones in dealing with the effects of PTSD. The Post Traumatic Stress Disorder Alliance is a resource for individuals with PTSD and helpful information for their family (www.ptsd-alliance.org).

Lisa M. Najavits, of Harvard Medical School and McLean Hospital, an expert on PTSD, and author of *Seeking Safety*, has developed a Web site, videos, and trainings to assist patients and clinical providers on issues such as PTSD (www.seekingsafety.org). This Web site is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. *Seeking Safety* has been used in the VA since the mid 1990s, and is currently implemented in a wide variety of VAs around the country. The Web-based information and training has been effectively used with both men and women veterans, at all levels of care, by all types of clinicians, in a group and individual format. These types of information and resources are provided to patients to assist in their treatment.

Additional Web-based resources are available through more commercial sites such as WebMD, and most relevantly through the Marine Corps' own MCCS program sites. For example, Site D's MCCS site contains a family services link where brochures and other information can be directly downloaded from the Web from any site (www.mccscp.com/family_services/counsleing/index.cfm). MCCS has a link that is designed specifically to deal with COS through its Combat Operational Stress Control (COSC) program (<http://www.usmc-mccs.org/cosc/>). The program encompasses prevention, identification, and holistically treats mental injuries caused by combat or other operations. COSC ensures that all Marines and family members who experience combat stress receive the best help possible. The two goals of COSC are to maintain a ready fighting force, and to protect and restore the health of Marines and their family members. The COSC branch provides resources for Marine leaders, chaplains, mental health professionals, medical providers, service members, veterans, family members, and their advocates. In particular, COSC has designed a COS Decision Matrix that can be used by Marines as a self-evaluation tool, and by leaders to assess where any Marine is at any given time on the stress continuum. The tool helps Marines identify their level of distress and loss of functioning, and lists actions to be taken including referrals to medical.

Client Education and Information Targeting Stigma

Stigma is a powerful force that can exert social control over individuals. When

applied to those with mental illness, stigma can not only have a marginalizing effect, but can also negatively influence their treatment-seeking behaviors. Mental illness is one of the most stigmatized conditions in our society (Alexander & Link, 2003). Research has found that only 23% to 40% of veterans identified as having a mental health problem sought any type of mental health service; the most common barrier was stigma related to seeking help for mental health issues (www.Health.Harvard.edu). Stigma, as a barrier to treatment, has many associated costs such as delays in treatment, which are associated with increased symptoms, family disruption, and organizational demands (Westphal, 2007). Service members with PTSD, and other combat related mental health difficulties, may seek alcohol or drugs as a way of easing symptoms, which can have a disastrous effect on their own wellbeing and on military readiness.

The perception of stigma continues to act as a barrier for many military members returning from recent conflicts. One possible reason for this apprehension is the fear of being labeled a “defective soldier” or service member. Psychologists have noted the need to address the shame associated with these feelings of weakness to treat patients dealing with combat-related psychological distress (Kraft, 2007, p.74-76). Seeking mental health support is often thought of as a detriment by soldiers who seek professional advancement and upward mobility in their military career. Britt, Greene-Shortridge, and Castro (2007) hypothesized that soldiers who perceive less stigma associated with seeking help will have a greater likelihood of seeking mental health care from professionals. These researchers also hypothesized that once soldiers seek help from mental health sources and have a positive experience, their perceptions of stigma may decrease.

The notion of exposing patients to educational interventions may increase knowledge about their conditions, which can potentially minimize their negative association with seeking help (Gray et al., 2004). Additional factors that may have promoted help seeking include recognition of symptoms, communication with a clinician, and unit-focused education around mental health issues, such as PTSD (Milliken, Auchterlonie, & Hoge, 2007). The information provided at the SACCs which are described above, are resources for patients regarding their condition. However, research has shown that educational alcohol-awareness activities, such as training and

interventions, would improve with a gender-tailored approach. (Lande, Marin, Chang, & Lande, 2007).

As mentioned above, patient education is a critical component to help with the treatment in a variety of settings. In the substance abuse setting it can help with adherence to treatment plans, when dealing with comorbid disorders—particularly those associated with stigma, and education information materials can help clients understand their condition (Cook et al., 2006). There is no single-best material or treatment for PTSD. Cognitive Behavioral Therapy includes a number of techniques such as cognitive restructuring, exposure therapy, desensitization, and group treatment (Patient Educational Institute – www.X-Plain.com). When comorbid symptoms exist it is best to treat both PTSD and the other disorder together rather than one at a time. There is no quick cure for PTSD; therapeutic strategies can be used to improve the patients' quality of life over time. However, when educational information is used in combination with mental health services it can significantly help the treatment process. (Gray et al., 2004).

III. Core Principles/Lessons Learned

- While all of the sites use some form of informational or educational material for their clients, there is no consistency to the material used.
- There is variance in the brochures and handouts available, the Web links on their base Web sites, and the use of worksheet materials either as homework or in counseling sessions.
- The demand for additional materials is universal.

IV. Recommendations/Future Directions

- A comprehensive set of client education handouts and materials should be packaged and made available for the SACCs to provide clients. A comprehensive list of Web-based resources should also be provided with suggestions on how to better make Web resources accessible to clients.

- Client materials targeted at reducing stigma for seeking help with substance use, COS, and PTSD should be developed and made available. These materials should also be provided outside of the clinical or counseling setting to further normalize the condition and encourage help-seeking prior to serious problem manifestation.
- Begin a major educational campaign to normalize the symptoms, and address barriers to seeking treatment among junior and senior leadership Marine Corps-wide.
- Provide additional PTSD and substance abuse educational services and materials for families focusing on early traumatization.
- Provide updated videos that the SACCs can use for instructional classes.

¹ SITE A specific brochures include: *Common Reactions Following Combat*, *Combat/Operational Stress Information for Marine Families and Friends*, and *Combat/Operational Stress Information for Marines*. SITE C specific brochures include: *The Quick Series Guide to Posttraumatic Stress Disorder for military personnel and their families*.

Chapter 7 – Resources

Listed below are documents and websites that may be useful resources for SACC staff.

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. Najavits, L.M.*

<http://www.seekingsafety.org/>

Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences and Services to Assist Recovery. Tanielian, T. and L.H. Jaycox (Eds.). RAND Corporation.*

http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf

Iraq War Clinician's Guide. National Center for Posttraumatic Stress Disorder.*

http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/iraq_clinician_guide_v2.pdf

*National Center for Posttraumatic Stress Disorder Clinical Newsletter.**

http://www.ncptsd.va.gov/ncmain/publications/publications/ncpbl_cq.jsp

http://www.ncptsd.va.gov/ncmain/nc_archives/clnc_qtly/V3N3_4.pdf?opm=1&rr=rr961&srt=d&echorr=true

Treatment Improvement Protocol (TIP) Series 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.* <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073>

Treatment Improvement Protocol Series 27: Comprehensive Case Management for Substance Abuse Treatment. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.*

<http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.49769>

National Center for Posttraumatic Stress Disorder: <http://www.ncptsd.va.gov/ncmain/index.jsp>

Organizations and References for use in the Substance Abuse Field http://www.projectcork.org/resource_materials/Organizations.html

An Achievable Vision: Report of the Department of Defense Task Force on Mental Health.

Department of Defense Task Force on Mental Health.* <http://www.taps.org/%5Cdownload%5CDOD%20Mental%20Health%20Task%20Force%20Report.pdf>

<http://www.taps.org/%5Cdownload%5CDOD%20Mental%20Health%20Task%20Force%20Report.pdf>

USMC Combat Operational Stress Control (COSC) and Marine Operational Stress Training

(MOST) Briefs: [https://www.manpower.usmc.mil/portal/page?_](https://www.manpower.usmc.mil/portal/page?_pageid=278,3260198&_dad=portal&_schema=PORTAL)

[pageid=278,3260198&_dad=portal&_schema=PORTAL](https://www.manpower.usmc.mil/portal/page?_pageid=278,3260198&_dad=portal&_schema=PORTAL)

Force Health Protection and Readiness: <http://www.deploymentlink.osd.mil/>

Mental Health Self-Assessment Program: <https://www.mentalhealthscreening.org/military/index.aspx>

TBI Clinical and Practical Guideline and Recommendations. Defense and Veterans Brain

Injury Center.* [http://www.pdhealth.mil/downloads/clinical_practice_guideline_](http://www.pdhealth.mil/downloads/clinical_practice_guideline_recommendations.pdf)

[recommendations.pdf](http://www.pdhealth.mil/downloads/clinical_practice_guideline_recommendations.pdf)

** For complete reference documentation for this resource, please see the references section.*

Chapter Eight

Overall Recommendations

A number of recommendations have been made within each topic area based upon core principles identified in the scientific literature and learned from the SACC site assessments. Each of the recommendations are designed to enhance the SACC's ability to address their clients with mental health concerns—particularly those with PTSD and COS symptoms, as well as depression and anxiety. However, it is recognized that not every counseling center can easily implement all of the recommendations.

Site characteristics and varying levels of available resources affect a SACC's ability to modify their processes and treatment approaches. Factors, such as having a Licensed Independent Practitioner or medical officer on-site at the SACC or having an on-base medical facility that provides mental health care, affect how easily mental health diagnoses can be confirmed, and how rapidly referrals for additional treatment can be made. Other factors anticipated to have a similar impact on a SACC's processes are the distance to the nearest substance abuse residential treatment facility (military or civilian), co-location with other counseling services, and whether the base is centrally or remotely located.

For these reasons, we have developed our overall listing of recommendations into two lists (see Table 3). The first column lists the fundamental recommendations that are the best practices and suggestions that all sites should strive to implement. The other column contains supplementary recommendations. These are practices that should be implemented as the site's resources and outside coordination allow. Fundamental recommendations are applicable to most SACC locations, and include suggestions such as identifying knowledge and skill gaps and promoting training opportunities for SACC counselors. Suggestions that may only apply to some SACC locations, such as assessing for mTBI or designating one SACC staff member as the site case manager, are examples of supplementary recommendations. It is our hope that these recommendations will lead to optimal referral and treatment of SACC clients suffering from PTSD and other military-related mental health conditions.

Table 3

Fundamental and Supplementary Recommendations for SACCs to Address Clients with Mental Health Concerns

Fundamental recommendations	Supplementary recommendations
Coordination, programming, and organizational factors	
<p>Create specific processes to welcome clients at the SACC. Counselors should anticipate that many of their substance abuse clients may also have co-occurring mental health concerns.</p> <p>Identify SACC staff knowledge and skill gaps in mental health/COS/PTSD, and promote training opportunities to fill these gaps. SACC Directors should empower their front line people, the counselors, who are encountering clients with multiple needs.</p> <p>Enhance communication between the SACC and mental health providers at on-base medical facilities by holding monthly meetings between these two groups and all other key stakeholders are recommended.</p>	<p>Co-locate SACC and other counseling services. This will increase communication and cross referrals between the counseling programs and facilitate providing multiple services to clients.</p>
Identification, screening, and assessment of mental health problems	
<p>Assess PTSD, depression, and anxiety among all SACC clients.</p> <p>Use standardized, validated screening tools appropriate for clients with substance problems from a military population. We recommend the following tools:</p> <p>PCL-C for assessing PTSD (Weathers et al., 1994).</p> <p>PHQ-9 for screening depression (Kroenke et al., 2003).</p> <p>GAD-7 Anxiety Scale Measure for screening for generalized anxiety disorder (Spitzer et al., 2006).</p> <p>DVBIC TBI Screening Tool is an option for counselors who want to screen for mTBI (http://www.dvbic.org/pdfs/3-Question-Screening-Tool.pdf).</p> <p>Provide feedback to clients about the results of any mental health screening, whether or not a referral is made.</p>	<p>mTBI is a brief additional optional assessment.</p> <p>Rescreen clients whose initial mental health screen did not result in a referral; however, counselors should use their own clinical judgment to decide when and how often to rescreen.</p>

Fundamental recommendations	Supplementary recommendations
Referrals and treatment	
<p>Develop and maintain a comprehensive list of mental health care referral points of contact, with the provider/facility treatment practices and areas of expertise, for treatment plan development and case management.</p> <p>Research suggests that a simultaneous treatment approach will be most effective in helping SACC clients with comorbidities; Promote the principles of <i>Seeking Safety</i> model (Najavits, 2002), which focuses on safety, integrated SA-PTSD treatment, and case management. Also encourage Marines in treatment to involve their family in the treatment and education process as much as possible.</p> <p>Define substance abuse post-treatment success (or failure) in a standardized way, and create specific plans of action for reassessing PTSD and SA among Marines who return to the SACC for additional treatment.</p> <p>Adapt current treatment programs to specifically address comorbid issues, and incorporate step-down SA-PTSD treatment concepts to help maintain the same treatment milieu throughout a client's recovery process.</p>	<p>Collaborate with USMC Headquarters to contract additional residential treatment facilities that are capable of concurrently treating SA-PTSD, have shorter admission wait times, and are more conveniently located for SACCs and the commands that they service.</p>
Case management and SACO coordination	
<p>Initiate more proactive case management practices, beginning at the SACC counselor level and following a client all the way through SA aftercare and psychological referral.</p> <p>Increase communication between SACC counselors and unit SACOs, to include monthly updates on the status of aftercare plan adherence throughout the one-year follow-up period.</p> <p>Improve unit SACO training to incorporate client management skills training, information on PTSD identification, warning signs, and mental health status screening questions.</p>	<p>Designate one dedicated case manager at each SACC if staffing allows, or ensure that each counselor fulfills the case management role.</p> <p>Ensure SACOs provide an adequate "turn-over" to their relief, especially when this occurs more frequently than the required 1-year SACO tour.</p> <p>Expand coverage of the AHLTA system to include computer terminals or workstations at each SACC. This includes providing the necessary infrastructure, computer equipment, and staff training.</p>

Fundamental recommendations	Supplementary recommendations
Case management and SACO coordination (continued...)	
<p>Create local standard operating procedures at each SACC to address “hand off” procedures for effectively managing client transfers and deployments.</p> <p>Coordinate with Military OneSource to facilitate referrals to a SACC in the anonymous “caller’s” location by providing the organization/contractor with a comprehensive list of SACC locations and SA inpatient treatment facilities.</p> <p>Reduce the barrier to mental health care by educating and engaging USMC leadership (“from the top down”) in the fight to dissolve stigma and negative attitudes about PTSD, COS, and mental health treatment. Additionally, implement organizational, command-level training that can be self-disseminated down to the unit level to further combat this barrier.</p>	
Client education and information	
<p>Develop a comprehensive set of client education handouts and materials, including Web-based resources, for SACCs to provide to their clients.</p> <p>Design client materials targeted at reducing perceived stigma for seeking help with substance abuse, COS, and PTSD.</p> <p>Provide additional PTSD and substance abuse educational services and materials for families focusing on early traumatization.</p>	<p>Begin a major educational campaign to normalize the symptoms and address barriers to seeking treatment among junior and senior leadership Marine Corps-wide.</p> <p>Update videos that SACCs can use for instructional classes.</p>

References

- Aboytes, J. (1993, Summer/Fall). PTSD substance abuse disorder unit at the national center clinical laboratory and education division. *National Center for Posttraumatic Stress Disorder Clinical Newsletter*, 3, 19-21.
- Abueg, F., Fairbank, J. (1991). Behavioral treatment of the PTSD-substance abuser: A multidimensional stage model. In P. Saigh (Ed.). *Posttraumatic stress disorder: A behavioral approach to assessment and treatment* (pp. 111-146). New York: Pergamon Press.
- Alexander, L. A., & Link, B. G. (2003). *The impact of contact on stigmatizing attitudes toward people with mental illness. J Ment Health*, 12, 271-289.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (4th ed., text revision). Arlington, VA: Author.
- Beck, A., & Beck, R. (1972). Screening depressed patients in family practice: A rapid technique. *Postgrad Med*, 52, 81-85.
- Beck, A, Steer, R., & Brown, G. (1996). *Manual for Beck Depression Inventory II (BDI-II)*. San Antonio: Psychology Corporation.
- Beck, A., Ward, C., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Arch Gen Psychiatry*, 4, 561-571.
- Boudewyns, P.A., Woods, M.G., Hyer, L., & Albrecht, J.W. (1991). Chronic combat-related PTSD and concurrent substance abuse: Implications for treatment of this frequent “dual diagnosis”. *J Trauma Stress*, 4, 549-560.
- Brady, K., Killeen, T., Saladin, M., Dansky, B., & Becker, S. (1994). Comorbid substance abuse and posttraumatic stress disorder: Characteristics of women in treatment. *Am J Addict*, 3, 160-164.
- Bray, R.M. Hourani, L.L., Rae Olmsted, K.L., Dever, J.A., Brown, J.M., Vincus, A.A., ... Pemberton, M.R. (2003). *2002 Department of Defense Survey of Health Related Behaviors Among Military Personnel* (Report No. RTI/7841/006-FR). Research Triangle Park, NC: Research Triangle Institute.
- Bray, R.M., Hourani, L.L., Rae Olmsted, K.L., Witt, M., Brown, J.M., Pemberton, M.R., ... Marsden, M.E. (2006). *2005 Department of Defense Survey of Health Related Behaviors Among Military Personnel* (Report No. RTI/7841/106-FR). Research

Triangle Park, NC: Research Triangle Institute.

Bray, R.M., Pemberton, M.R., Hourani, L.L., Witt, M., Rae Olmsted, K.L., Brown, J.M., ...Weimer, B. (2009). *2009 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel* (Report No. RTI/10940-FR).

Research Triangle Park, NC: Research Triangle Institute.

Bremner, J.D., Southwick, S.M., Darnell, A., & Charney, D.S. (1996). Chronic PTSD in Vietnam combat veterans: course of illness and substance abuse. *Am J Psychiatry*, 153(3), 369-375.

Breslau, N., Davis, G.C., Andreski, P., & Peterson, E. (1991). Traumatic event and posttraumatic stress disorder in an urban population of young adults. *Arch Gen Psychiatry*, 48, 216-222.

Breslau, N., Davis, G.C., Peterson, E.L., & Schultz, L. (1997). Psychiatric Sequelae of posttraumatic stress disorder in women. *Arch Gen Psychiatry*, 54, 81-87.

Britt, T.W., Greene-Shortridge, T.M., Castro, C.A. (2007). The Stigma of mental health problems in the military. *Mil Med*, 172(2), 157-161.

Brown, P.J., & Wolfe, J. (1994). Substance abuse and posttraumatic stress disorder comorbidity. *Drug and Alcohol Depend*, 35, 51-59.

Brown, P., Recupero, P., & Stout, R. (1995). PTSD substance abuse comorbidity and treatment utilization. *Addict Behav*, 20, 251-254.

Brown, P.J., Stout, R.L., & Gannon-Rowley, J. (1998). Substance use disorder – PTSD comorbidity and treatment utilization. *Addict Behav*, 20, 251-254.

Brown, P., Stout, R., & Mueller, T. (1999). Substance use disorder and posttraumatic stress disorder comorbidity: Addiction and psychiatric treatment rates. *Psychol Addict Behav*, 13, 115-122.

Brownson, K. (1998). Education handouts: Are we wasting our time? *J Nurses Staff Dev*, 14(4), 176-182.

Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, 8, 431-441.

Carlson, E., & Waelde, L. (2000). *Preliminary psychometric properties of the Trauma Related Dissociation Scale*. Paper presented at the Annual meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.

- Cook, J.M., Walser, R.D., Kane, V., Ruzek, J.I., & Woody, G. (2006). Dissemination and Feasibility of a cognitive behavioral treatment for substance use disorders and posttraumatic stress disorder in the veterans administration. *J Psychoactive Drugs*, 38(1) 89-92.
- Combat Operational Stress Control (COSC). (2008). *USMC Combat Operational Stress Continuum and Decision Matrix*. Retrieved from https://www.manpower.usmc.mil/portal/page?_pageid=278,3289827&_dad=portal&_schema=PORTAL
- Corrigan, J., Smith-Kanpp, K., & Granger, CV. (1998). Outcomes in the first 5 years after traumatic brain injury. *Arch Phys Med Rehabil*, 79, 298-305.
- Corrigan, J., Rust, E., & Lamb-Hart, G. (1995). The nature and extent of substance abuse problems among persons with traumatic brain injuries. *J Head Trauma Rehabil*, 10, 29-45.
- Department of Defense Task Force on Mental Health (2007a). *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health*. Falls Church, VA: Defense Health Board.
- Department of Defense Task Force on Mental Health (2007b). *The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health: Report to Congress*. Washington, DC: Author.
- Department of the Navy. (2001). *Marine Corps Order P1700.24B (Change 1 27DEC01): Marine Corps Personal Services Manual*. Washington, DC: Headquarters United States Marine Corps.
- Department of the Navy. (1999). *SECNAV Instruction 5300.28C: Military Substance Abuse Prevention and Control*. Washington, DC: Author.
- Defense and Veterans Affairs. (2007). Screening and evaluation of possible Traumatic Brain Injury in Operation Enduring Freedom and Operation Iraqi Freedom Veterans (Veterans Health Administration, VHA Directive 2007-013). Retrieved from http://www1.va.gov/optometry/docs/VHA_Directive_2007-013.pdf
- Douglas, K., Taylor, A., & O'Malley, P. (2004). Relationship between depression and C-reactive protein in a screening population. *Psychosom Med*, 66, 679-683.
- ETP, Inc. (Ed.) (1998). *Department of the Navy Bureau of Medicine and Surgery: Alcohol and Drug Abuse Program Counselor Workbook*. Retrieved from

<http://www.clinicalpreceptor.com/index.asp/>

- Evans, K. & Sullivan, J.M. (1995). *Treating Addicted Survivors of Trauma*. New York: Guilford Press.
- Felker, B., Hawkins, E., Dobie, D., Gutierrez, J., & McFall, M. (2008). Characteristics of deployed Operation Iraqi Freedom military personnel who seek mental health care. *Mil Med*, 173, 155-158.
- Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of PTSD: The Posttraumatic Diagnostic Scale. *Psychol Assess*, 9, 445-451.
- Foa, E., Riggs, D., Dancu, C., & Rothbaum, B. (1993). Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *J Trauma Stress*, 6, 459-473.
- Friedman, M.J. (2006). Posttraumatic stress disorder among military returnees from Afghanistan and Iraq. *Am J Psychiatry*, 163, 586-593.
- Friedman, M.J. (1993, Summer/Fall). On treating alcoholism and drug abuse in patients with PTSD. *National Center for Posttraumatic Stress Disorder Clinical Newsletter*, 3, 4-5.
- Frueh, C.B., Buckley, T.C., Cusack, K.J., Kimble, M.O., Grubaugh, A.L., Turner, S.M., & Keane, T.M. (2004). Cognitive-behavioral treatment for PTSD among people with severe mental illness: a proposed treatment model. *J Psychiatr Pract*, 10(1), 26-38.
- Gahm, G., & Lucenko, B. (2007). Screening soldiers in outpatient care for mental health concerns. *Mil Med*, 173, 17-24.
- Grant, B., Stinson, F., Dawson, D., Chou, P., Dufour, M., Compton, W.,... Pickering, R.P. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch Gen Psychiatry*, 61, 807-816.
- Gray, J.M., Elhai, J.D., & Frueh, B.C. (2004, Winter). Enhancing patient satisfaction and increasing treatment compliance: Patient education as a fundamental component of PTSD treatment. *Psychiatr Q*, 75(4), 321-332.
- Green, B. (1996). Trauma history questionnaire. In B. Stamm (Ed.). *Measurement of stress, trauma, and adaptation* (pp. 366-369). Lutherville, MD: Sidran Press.
- Greenberg, P., Kessler, R., Nells, T., Finkelstein, S., & Berndt, E. (1996). Depression in the workplace: an economic perspective. In J.P. Feighner & W.F. Boyer (Eds.).

- Selective serotonin re-uptake inhibitors: Advances in basic research and clinical practice* (pp. 327-63). New York: John Wiley and Sons.
- Greenfield, S.F., Weiss, R.D., Muenz, L.R., Vagge, L.M., Kelly, J.F., Bello, L.R., & Michael, J. (1998). The effect of depression on return to drinking: A prospective study. *Arc Gen Psychiatry*, 55(3), 259–265.
- Helzer, J., & Pryzbeck, T. (1988). The co-occurrence of alcoholism with other psychiatric disorders in the general population and its impact on treatment. *J Stud Alcohol*, 49, 219–224.
- Hendrickson, E.L., Schmal, M.S., & Ekleberry S.C. (2004). *Treating Co-Occurring Disorders: A Handbook for Mental Health and Substance Abuse Professionals*. (pp. 196). Binghamton, NY: Hayworth Press, Inc.
- Henry, L. (1998). Demand management: The patient education connection. *Fam Pract Manag*, 5(8), 65-70.
- Hernan, J.L. (1992). *Trauma and recovery*. New York: Basic Books.
- Hoge, C., McGurk, D., Thomas, J., Cox, A., Engel, C., & Castro, C. (2008). Mild traumatic brain injury in U.S. soldiers returning from Iraq. *N Engl J Med*, 358, 453-463.
- Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med*, 351, 13-22.
- Hyer, L., McCranie, E., & Peralme, L. (1993, Summer/Fall). Dual diagnosis: PTSD and alcohol abuse. *National Center for Posttraumatic Stress Disorder Clinical Newsletter*, 3, 1-10.
- Imhof, J. (1991). Countertransference issues in alcoholism and drug addiction. *Psychiatr Ann*, 21, 292-306.
- Imhof, J., Hirsch, R., & Terenzi, R. (1983). Countertransfereential and attitudinal considerations in the treatment of drug abuse and addiction. *Int J Addict*, 18, 491-510.
- Jacobsen, L.K., Southwick, S.M., and Kosten, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *Am J Psychiatry*, 158(8), 1184-1190.
- Kendler, K, Gallagher, T., Abelson, J., & Kessler, R. (1996). Lifetime prevalence,

demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample: The National Comorbidity Survey. *Arch Gen Psychiatry*, 53, 1022-1031.

Kennedy, C., Jones, D., & Grayson, R. (2006). Substance abuse services and gambling treatment in the military. In C. Kennedy & E. Zillmer (Eds.). *Military psychology: Clinical and operational applications* (pp.163-190). New York: Guilford Press.

Kessler, R., Crum, R., Warner, L., Nelson, C., Schulenberg, J., & Anthony, J. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Arch Gen Psychiatry*, 54, 313–321.

Kessler, R., McGonagle, K., Zhao, S., Nelson, C., Hughes, M., Eshleman, S., ...
Witcher, H. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Arch Gen Psychiatry*, 51, 8–19.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry*, 52, 1048-1060.

Kraft, H.S. (2007). *Rule Number Two: Lessons I Learned in a Combat Hospital*. New York, NY: Little, Brown & Co.

Kreutzer, J., Witol, A., Sander, A., Cifu, D., Marwitz, J., & Delmonico, R. (1996). A prospective longitudinal multicenter analysis of alcohol use patterns among persons with traumatic brain injury. *J Head Trauma Rehabil*, 11, 58-69.

Kreutzer, J., Witol, A., & Marwitz, J. (1996). Alcohol and drug use among young persons with traumatic brain injury. *J Learn Disabil*, 29, 643-651.

Kroenke, K., & Spitzer, R. (1998). Gender difference in the reporting of physical and somatoform symptoms. *Psychosom Med*, 60, 150-155

Kroenke, K., Spitzer, R., & Williams, J. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Med Care*, 41, 1284-92.

Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *J Gen Int Med*, 16, 606-613.

Kroenke, K.; Spitzer, R., Williams, J., Monahan, P., & Löwe, B. (2007). Anxiety

- Disorders in Primary Care: Prevalence, Impairment, Comorbidity, and Detection. *Ann Int Med*, 146(5), 317-325.
- Kulka, R.A., Schlenger, W.E., Fairbank, I.A., Hough, R.L., Jordan, B.K., Marmar, C.R., Weiss, D. (1988). Contractual Report of the Findings from the National Vietnam Veterans Readjustment Study. Research Triangle Park, NC: Research Triangle Institute.
- Kulka, R., Schlenger, W., Fairbank, J., Hough, R., Jordan, B., Marmar, C., ... Weiss, D. (1990). Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study. Philadelphia: Brunner/Mazel.
- Kubany, E., Haynes, S., Leisen, M., Owens, J., Kaplan, A., Watson, S., & Burns, K. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychol Assess*, 12, 210-224.
- Kushner, M., Abrams, K., Thuras, P., Hanson, K., Brekke, M., & Sletten, S. (2005). A follow-up study of anxiety disorder and alcohol dependence in comorbid alcoholism treatment patients. *Alcohol Clin Exp Res*, 29, 1432-1443.
- Kushner, M., Abrams, K., & Borchardt, C. (2000). The relationship between anxiety disorders and alcohol use disorder: A review of major perspectives and findings. *Clin Psychol Rev*, 20, 149-171.
- Lande, R.G., Marin, B.A., Chang, A.S., & Lande, G.R. (2007). Gender differences and alcohol use in the US Army. *J Am Osteopath Assoc*, 107(9), 401-7.
- Larson, G., Highfill-McRoy, R., Booth-Kewley, S. (2008). Psychiatric diagnoses in historic and contemporary military cohorts: combat deployment and the healthy warrior effect. *Am J Epidemiol*, 167(11), 1269-76.
- Levin, A. (2008). Army hopes program makes soldiers more apt to get MH care. *Psychiatr News*, 43, 4.
- Marshall, J. (2008). Medical management of co-morbid anxiety and substance use disorder. In S. Stewart & P. Conrad (Eds.). *Anxiety and substance use disorders: The vicious cycle of comorbidity* (pp.221-236). New York: Springer.
- Maynard, A.M. (1999). Preparing readable patient education handouts. *J Nurses Staff Dev*, 15(1), 11-18.

- McKaughan, J. (2007). *Interview with Major General Elder Granger*. Retrieved from http://www.military-medical-technology.com/print_article.cfm?DocID=1882/
- Meyer, R., & Kranzler, H. (1990). Alcohol abuse/dependence and co-morbid anxiety and depression. In: J. Maser & C. Cloninger. (Eds). *Comorbidity of mood and anxiety disorders* (pp. 283–292). Washington DC: American Psychiatric Press.
- Milliken, C.S., Auchterlonie, J.L., & Hoge, C.W. (2007) Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War. *JAMA*, 298 (18), 2141-48.
- Minkoff, K., & Cline, C.A. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatr Clin North Am*, 27(4), 727-43.
- Minkoff, K. (2008a). *Integrated scope of practice for singly-trained clinicians working with clients with co-occurring disorders*. Clinical Preceptorship Training Conference, May 4, 2008, San Diego, CA.
- Minkoff, K. (2008b). *Comprehensive, continuous, integrated system of care model*. Clinical Preceptorship Training Conference, May 4, 2008, San Diego, CA.
- Najavits, L.M (2002) *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford.
- Najavits, L.M. (2004). Assessment of trauma, PTSD, and substance use disorder: A practical guide. In: J.P. Wilson & T. Kean (Eds.). *Assessing psychological trauma and PTSD* (2nd ed). (pp 466-491). New York: Guilford Press.
- Najavits, L.M. (2007). Seeking safety: An evidence-based model for substance abuse and trauma/PTSD. In K.A. Witkiewitz & G.A. Marlatt (Eds.). *Therapists Guide to Evidence-Based Relapse prevention: Practical Resource for the Mental Health Professional*. (pp 141-167). San Diego: Elsevier Press.
- Najavits, L.M., Gastfriend, D.R., Barber, J.P. Reif, S., Muenz, L.R., Blaine, J., ... Frank, A. (1998). Cocaine dependence with and without posttraumatic stress disorder among subjects in the NIDA Collaborative Cocaine Treatment Study. *Am J Psychiatry*, 155, 214-219.
- Najavits, L.M., Griffin, M.L., Luborsky, L., Frank, A., Weiss, R.D., Liese, B.S., ... Thompson, H. (1995). Therapists' emotional reactions to substance abusers: A new

- questionnaire and initial findings. *Psychotherapy*, 32, 669-677.
- Najavits, L.M., Shaw, S.R. & Weiss, R.D. (1996a). *Outcome of a new psychotherapy for women with posttraumatic stress disorder and substance dependence*. Paper presented at the meeting of the College of Physicians on Drug Dependence, San Juan, Puerto Rico.
- Najavits, L.M., Weiss, R.D., & Liese, B.S. (1996b). Group cognitive-behavioral therapy for women with PTSD and substance use disorder. *Journal of Substance Abuse Treatment*. 13, 13-22.
- National Institute of Mental Health. (2007). Depression. Retrieved August 8, 2008 from <http://www.nimh.nih.gov/health/publications/depression/nimhdepression.pdf>
- National Center for Posttraumatic Stress Disorder. (2004). *Iraq War Clinician's Guide* (p. 32). White River Junction, VT: Author.
- NAVMC 2931: *Marine Corps Drug and Alcohol Abuse Prevention and Treatment Program*. Retrieved August 4, 2008 from <http://www.usmc-mccs.org/aboutmccs/downloads/NAVMC%202931-revised%20feb01.pdf/>
- Olfson, M., Fireman, B., Weissman, M.M., Leon, A.C., Sheehan, D.V., Kathol, R.G., ... Hoven, C. (1997). Mental disorders and disability among patients in a primary care group practice. *Am J Psychiatry*, 154(12), 7.
- Ommaya, A., Dannenberg, A., & Salazar, A. (1996). Causation, incidence, and costs of traumatic brain injury in the U.S. military medical system. *J Trauma*, 40, 211-217.
- Ormel, J., VonKorff, M., Ustun, T.B., Pini, S., Korten, A., & Oldehinkel, T. (1994). Common mental disorders and disability across cultures: Results from the WHO Collaborative Study on Psychological Problems in General Health Care. *JAMA*, 272(22), 1741-1748.
- Ouimette, P., Brown, P., Najavits, L. (1998). Course and treatment of patients with both substance use and posttraumatic stress disorders. *Addict Behav*, 23, 785-795.
- Penk, W. (1993, Summer/Fall). PTSD and substance abuse: Clinical assessment considerations. *National Center for Posttraumatic Stress Disorder Clinical Newsletter*, 3, 14-18.
- Quello, S., Brady, K., & Sonne, S. (2005). Mood disorders and substance use disorder: A complex comorbidity. *Sci Pract Perspect*, 3, 13-21.

- Read, J.P., Bollinger, A.R., & Sharkansky, E. (2003). Assessment of comorbid substance use disorder and posttraumatic stress disorder. In P. Ouimette & P. Brown (Eds.). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 111-125). Washington D.C.: American Psychological Association.
- Russell, M.C. (2007). *Military Mental Health Care and the Global War on Terrorism: A Critical Analysis from the Field Part Two: Meeting the Mental Health Need*. Yokosuka, Japan: Naval Hospital.
- Ruzek, J.I., Polusny, M.A., & Abueg, F.R. (1998). Assessment and treatment of concurrent posttraumatic stress disorder and substance abuse. In V.M. Folette, J.I. Ruzek, & F.R. Abueg (Eds.). *Cognitive-Behavioral Therapies for Trauma* (p. 226-255). New York: Guilford Press.
- Saladin, M.E., Brady, K.T., Dansky, B.S., & Kilpatrick, D.G. (1995). Understanding comorbidity between PTSD and substance use disorders: Two preliminary investigations. *Addict Behav*, 20, 643-655.
- Satel, S.L., Becker, B.R., & Dan, E. (1993). Reducing obstacles to affiliation with Alcoholics Anonymous among veterans with PTSD and alcoholism. *Hosp Community Psychiatry*, 44, 1061-1065.
- Schwab, K., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology*, 66, A235.
- Shalev, A.Y., Freedman, S., Peri, T., Brandes, D., Sahar, T., Orr, S.P., & Pitman, R. (1998). Prospective study of posttraumatic stress disorder and depression following trauma. *Am J Psychiatry*, 155(5), 630-637.
- Sheridan, C., Mulhern, M., & Martine, D. (1999). The role of social desirability, negative affectivity, and female reproductive symptoms in differences in reporting symptoms by men and women. *Psychol Rep*, 85, 54-62.
- Solomon, S.D., Gerrity, E.T., & Muff, A.M. (1992). Efficacy of treatments for posttraumatic stress disorder. *JAMA*, 268, 633-638.
- Spitzer, R., Kroenke, K., Williams, J., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Arch Intern Med*, 166, 1092-1097.

- Stamm, B., Rudolph, J., Dewane, S., Gaines, N., Gorton, K., Paul, G., ... McNeil, F. (1996). Psychometric Review of Stressful Life Experiences Screening. In B.H. Stamm (Ed.). *Measurement of Stress, Trauma and Adaptation*. Lutherville, MD: Sidran Press.
- Stander, V. (2008). *Operational Stress and Substance Use*. Presented to Headquarters Marine Corps, Quantico, VA.
- Tanielian, T. & Jaycox, L.H. (Eds.). (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences and Services to Assist Recovery* (RAND, Center for Military Health Policy Research, p. 255, 274). Santa Monica: RAND Corporation.
- Taylor, L., Kreutzer, S., Demm, S., & Meade, M. (2003). Traumatic brain injury and substance abuse: A review and analysis of the literature. *Neuropsychol Rehabil*, 13, 165–188.
- Tyson, A.S. (2008, May 28). Military diagnosing more posttraumatic stress. *The Washington Post*. Retrieved from <http://www.washingtonpost.com>
- U.S. Department of Defense Military Health System. (2008). *Dealing with Depression*. Retrieved August 8, 2008 from <http://afterdeployment.org>
- U.S. Department of Health and Human Services. (1998). *Treatment Improvement Protocol Series 27: Comprehensive Case Management for Substance Abuse Treatment* (Center for Substance Abuse Treatment, DHHS Publication No. 98-3222). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- U.S. Department of Health and Human Services. (2005). *Treatment Improvement Protocol Series 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders* (Center for Substance Abuse Treatment, DHHS Publication No. 05-3922). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- U.S. Preventive Services Task Force. (2002). *Screening for Depression: Recommendations and Rationale*. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from <http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm>
- U.S. Preventive Services Task Force. (2004). Screening for suicide risk: Recommendation and rationale. *Ann Int Med*, 140, 822-835.

- Warner, C., Breitbach, J., Rachal, J., Matuszak, T., & Grieger, T. (2007). *Depression in entry-level military personnel. Mil Med, 172*, 797-799.
- Weathers, F., Huska, J., & Keane, T. (1991). *The PTSD Checklist Military Version (PCL-M)*. Boston: National Center for PTSD.
- Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (1993, October). *The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility*. Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.
- Weathers, F., Litz, B., Huska, J., & Keane, T. (1994). *PTSD Checklist (PCL) for DSM-IV*. Boston: National Center for PTSD.
- Westphal, R. J. (2007). *Fleet leaders' attitudes about subordinates' use of mental health services. Mil Med, 172*, 1138-43.
- Wolfe, J., & Kimerling, R. (1997). Gender issues in the assessment of PTSD. In J. Wilson & T. Keane (Eds.). *Assessing psychological trauma and PTSD* (pp. 192-238). New York: Guilford.
- Wright, K., Adler, A., Bliese, P., & Eckford, R. (2008). Structured clinical interview guide for postdeployment psychological screening programs. *Mil Med, 173*, 411-421.
- Wyman, K., & Castle, D. (2006). Anxiety and substance use disorder comorbidity: Prevalence, explanatory models and treatment implications. *J Dual Diagn, 2*, 93-119.

Appendix A

Combined Tool for Mental Health Screening Among SACC Clients

A

Below is a list of reactions that Marines sometimes experience following deployment or in response to other stressful life experiences. Please indicate how much you have been bothered by each problem in the past month.

	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
a. Repeated, disturbing memories, thoughts, or images of a stressful experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Repeated, disturbing dreams of a stressful experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling very upset when something reminded you of a stressful experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Having physical reactions (like heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Avoiding activities or situations because they reminded you of a stressful experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Trouble remembering important parts of a stressful experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Loss of interest in activities you used to enjoy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Feeling distant or cut off from other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Feeling emotionally numb or being unable to have loving feelings for those close to you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Feeling as if your future somehow will be cut short	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Trouble falling asleep or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Feeling irritable or having angry outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Having difficulty concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Being "super alert" or watchful or on guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Feeling jumpy or easily startled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Sources:

A. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). *The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility*. Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

B. Copyright © 2008 Pfizer Inc. All rights reserved. Kroenke, K., Spitzer, R., Williams, J. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613.

C. Spitzer RL, Kroenke K, Williams JB, Lowe B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Arch Intern Med*, 166(10), 1092-7.

**Please continue to
the next page.**

BOver the last 2 weeks, how often have you been bothered by the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered “**Not at all**” to **both** of the first two questions above, please **go to** step **C**.Otherwise, please **complete** the next seven questions.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Over the last 2 weeks, how often have you been bothered by the following problems?**C**

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered “**Not at all**” to **both** of the first two questions above, you have finished.Otherwise, please **complete** the next five questions.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
3. Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Being so restless that it's hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix B



3 Question DVBIC TBI Screening Tool Instruction Sheet

Purpose and Use of the DVBIC 3 Question TBI Screen

The purpose of this screen is to identify service members who may need further evaluation for mild traumatic brain injury (MTBI).

Tool Development

The 3 Question DVBIC TBI Screening Tool, also called The Brief Traumatic Brain Injury Screen (BTBIS), was validated in a small, initial study conducted with active duty service members who served in Iraq/Afghanistan between January 2004 and January 2005.

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology*, 66(5)(Supp. 2), A235.

Who to Screen

Screen should be used with service members who were injured during combat operations, training missions or other activities.

Screening Instructions

Question 1: A checked [✓] response to any item A through F verifies injury.

Question 2: A checked [✓] response to A-E meets criteria for a positive (+) screen. Further interview is indicated. A positive response to F or G does not indicate a positive screen, but should be further evaluated in a clinical interview.

Question 3: Endorsement of any item A-H verifies current symptoms which may be related to an MTBI if the screening and interview process determines a MTBI occurred.

Significance of Positive Screen

A service member who endorses an injury [Question 1], as well as an alteration of consciousness [Question 2 A-E], should be further evaluated via clinical interview because he/she is more highly suspect for having sustained an MTBI or concussion. The MTBI screen alone does not provide diagnosis of MTBI. A clinical interview is required.

Telephone: 1-800-870-9244

For more information contact:

Email: info@DVBIC.org

Web: www.DVBIC.org



3 Question DVBIC TBI Screening Tool

1. Did you have any injury(ies) during your deployment from any of the following?
(check all that apply):

- A. ☐ Fragment
- B. ☐ Bullet
- C. ☐ Vehicular (any type of vehicle, including airplane)
- D. ☐ Fall
- E. ☐ Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)
- F. ☐ Other specify: _____

2. Did any injury received while you were deployed result in any of the following?
(check all that apply):

- A. ☐ Being dazed, confused or "seeing stars"
- B. ☐ Not remembering the injury
- C. ☐ Losing consciousness (knocked out) for less than a minute
- D. ☐ Losing consciousness for 1-20 minutes
- E. ☐ Losing consciousness for longer than 20 minutes

NOTE: Endorsement
of A-E meets criteria for
positive TBI Screen

- F. ☐ Having any symptoms of concussion afterward
(such as headache, dizziness, irritability, etc.)
- G. ☐ Head Injury

NOTE: Confirm F and G
through clinical interview

- H. ☐ None of the above

3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion?
(check all that apply):

- | | |
|--|--|
| A. <input type="checkbox"/> Headaches | E. <input type="checkbox"/> Ringing in the ears |
| B. <input type="checkbox"/> Dizziness | F. <input type="checkbox"/> Irritability |
| C. <input type="checkbox"/> Memory problems | G. <input type="checkbox"/> Sleep problems |
| D. <input type="checkbox"/> Balance problems | H. <input type="checkbox"/> Other specify: _____ |

Schwab, K. A., Baker, G., Ivins, B., Sluss-Tiller, M., Lux, W., & Warden, D. (2006). The Brief Traumatic Brain Injury Screen (BTBIS): Investigating the validity of a self-report instrument for detecting traumatic brain injury (TBI) in troops returning from deployment in Afghanistan and Iraq. *Neurology*, 66(5)(Supp. 2), A235.

Telephone: 1-800-870-9244

For more information contact:

Email: info@DVBIC.org

Web: www.DVBIC.org

Appendix C

Patient Placement Criteria Grid					
DIMENSIONS	EARLY INTERVENTION	OUTPATIENT	INTENSIVE OUTPATIENT	RESIDENTIAL	MEDICALLY MANAGED
WITHDRAWAL	No significant risk	No significant risk	No significant risk	No significant risk	Significant withdrawal risk
BIOMEDICAL	If biomedical problems, non-interfering	If biomedical problems, non-interfering	If biomedical problems, non-interfering	If biomedical problems, non-interfering	Requires 24-hour medical/nursing care
EMOTIONAL/BEHAVIORAL	If emotional/behavior problems, non-interfering	If emotional/behavior problems, requires minimal structure and support	If emotional/behavior problems, requires minimal structure and support	Alcohol Dependent emotional/behavioral problems interfere, require Milieu setting	Severe problems require 24-hour psychiatric care
PROGRAM/TREATMENT ACCEPTANCE	Willing to participate	Motivated and/or willing to cooperate	Acknowledges problem. Requires monitoring/motivation	Acknowledges problem. Requires Milieu setting	N/A
RELAPSE POTENTIAL	Able to achieve program goals in an educational setting	Able to maintain abstinence and achieve treatment goals with minimal support and structure	Able to maintain abstinence and achieve treatment goals with close monitoring and support	High likelihood of use without close monitoring in a Milieu setting	N/A
RECOVERY ENVIRONMENT	Supportive environment and/or skills to cope	Supportive environment and/or skills to cope	Coping skills and/or recovery environment requires additional support	Unable to cope with recovery environment, needs Milieu setting	N/A
OPERATIONAL COMMITMENTS	N/A	Command willing to commit to treatment requirements	Command willing to commit to treatment requirements	Schedule does not allow participation in another treatment program at this time	N/A

Note. Table from NAVMC 2931: Marine Corps Drug and Alcohol Abuse Prevention and Treatment Program. <http://www.usmc-mccs.org/aboutmccs/downloads/NAVMC%202931-revised%202feb01.pdf/>

REPORT DOCUMENTATION PAGE

The public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB Control number. **PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.**

1. Report Date (DD MM YY) 02 08 10		2. Report Type Technical Report		3. DATES COVERED (from - to) Sept 2007–Aug 2009									
4. TITLE AND SUBTITLE Best Practices for Addressing Combat Operational Stress and Other Behavioral Health Conditions in Marine Corps Substance Abuse Counseling Centers				5a. Contract Number: 5b. Grant Number: 5c. Program Element: 5d. Project Number: 5e. Task Number: 5f. Work Unit Number: 60714									
6. AUTHORS Hurtado, Suzanne L.; Crain, Jenny A.; McRoy, Robyn M.; Simon-Arndt, Cynthia M.; Larson, Gerald E.; Smallidge, Tara M.													
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Commanding Officer Naval Health Research Center 140 Sylvester Rd. San Diego, CA 92106-3521													
9. SPONSORING/MONITORING AGENCY NAMES(S) AND ADDRESS(ES) <table border="0"><tr><td>Commanding Officer</td><td>Commander</td></tr><tr><td>Naval Medical Research Center</td><td>Navy Medicine Support Command</td></tr><tr><td>503 Robert Grant Ave</td><td>P.O. Box 140</td></tr><tr><td>Silver Spring, MD 20910-7500</td><td>Jacksonville, FL 32212-0140</td></tr></table>				Commanding Officer	Commander	Naval Medical Research Center	Navy Medicine Support Command	503 Robert Grant Ave	P.O. Box 140	Silver Spring, MD 20910-7500	Jacksonville, FL 32212-0140	8. PERFORMING ORGANIZATION REPORT NUMBER Report No. 10-25	
				Commanding Officer	Commander								
Naval Medical Research Center	Navy Medicine Support Command												
503 Robert Grant Ave	P.O. Box 140												
Silver Spring, MD 20910-7500	Jacksonville, FL 32212-0140												
				10. Sponsor/Monitor's Acronyms(s) NMRC/NMSC									
				11. Sponsor/Monitor's Report Number(s)									
12 DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited.													
13. SUPPLEMENTARY NOTES Do not cite, quote, or release until publication.													
14. ABSTRACT (maximum 200 words) The Naval Health Research Center was tasked by Headquarters Marine Corps with assessing the process by which the Marine Corps Substance Abuse Counseling Centers (SACCs) address clients with stress concerns and behavioral health conditions stemming from deployment, such as post-traumatic stress disorder (PTSD) and combat operational stress. The following report details findings from the scientific literature and SACC site assessments, and provides specific recommendations. It documents the current treatment approach with regard to substance abuse clients with co-occurring mental health concerns at selected Marine Corps SACCs; and it reviews and recommends best practices for screening, referrals, treatment, patient education, and case management. The overall purpose is to provide recommendations that will lead to optimal treatment of SACC clients suffering from PTSD and other military-related behavioral health conditions.													
14. SUBJECT TERMS substance abuse, counseling, posttraumatic stress disorder, PTSD, combat operational stress, COS, behavioral health, mental health, referral, screening, Marine Corps													
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT UNCL	18. NUMBER OF PAGES 99	18a. NAME OF RESPONSIBLE PERSON Commanding Officer								
a. REPORT UNCL	b. ABSTRACT UNCL	b. THIS PAGE UNCL			18b. TELEPHONE NUMBER (INCLUDING AREA CODE) COMM/DSN: (619) 553-8429								

REPORT DOCUMENTATION PAGE

The public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB Control number. **PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.**

1. Report Date (DD MM YY) 02 08 10		2. Report Type Technical Report		3. DATES COVERED (from - to) Sept 2007–Aug 2009									
4. TITLE AND SUBTITLE Best Practices for Addressing Combat Operational Stress and Other Behavioral Health Conditions in Marine Corps Substance Abuse Counseling Centers				5a. Contract Number: 5b. Grant Number: 5c. Program Element: 5d. Project Number: 5e. Task Number: 5f. Work Unit Number: 60714									
6. AUTHORS Hurtado, Suzanne L.; Crain, Jenny A.; McRoy, Robyn M.; Simon-Arndt, Cynthia M.; Larson, Gerald E.; Smallidge, Tara M.													
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Commanding Officer Naval Health Research Center 140 Sylvester Rd. San Diego, CA 92106-3521													
9. SPONSORING/MONITORING AGENCY NAMES(S) AND ADDRESS(ES) <table border="0"><tr><td>Commanding Officer</td><td>Commander</td></tr><tr><td>Naval Medical Research Center</td><td>Navy Medicine Support Command</td></tr><tr><td>503 Robert Grant Ave</td><td>P.O. Box 140</td></tr><tr><td>Silver Spring, MD 20910-7500</td><td>Jacksonville, FL 32212-0140</td></tr></table>				Commanding Officer	Commander	Naval Medical Research Center	Navy Medicine Support Command	503 Robert Grant Ave	P.O. Box 140	Silver Spring, MD 20910-7500	Jacksonville, FL 32212-0140	8. PERFORMING ORGANIZATION REPORT NUMBER Report No. 10-25	
				Commanding Officer	Commander								
Naval Medical Research Center	Navy Medicine Support Command												
503 Robert Grant Ave	P.O. Box 140												
Silver Spring, MD 20910-7500	Jacksonville, FL 32212-0140												
				10. Sponsor/Monitor's Acronyms(s) NMRC/NMSC									
				11. Sponsor/Monitor's Report Number(s)									
12 DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited.													
13. SUPPLEMENTARY NOTES Do not cite, quote, or release until publication.													
14. ABSTRACT (maximum 200 words) The Naval Health Research Center was tasked by Headquarters Marine Corps with assessing the process by which the Marine Corps Substance Abuse Counseling Centers (SACCs) address clients with stress concerns and behavioral health conditions stemming from deployment, such as post-traumatic stress disorder (PTSD) and combat operational stress. The following report details findings from the scientific literature and SACC site assessments, and provides specific recommendations. It documents the current treatment approach with regard to substance abuse clients with co-occurring mental health concerns at selected Marine Corps SACCs; and it reviews and recommends best practices for screening, referrals, treatment, patient education, and case management. The overall purpose is to provide recommendations that will lead to optimal treatment of SACC clients suffering from PTSD and other military-related behavioral health conditions.													
14. SUBJECT TERMS substance abuse, counseling, posttraumatic stress disorder, PTSD, combat operational stress, COS, behavioral health, mental health, referral, screening, Marine Corps													
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT UNCL	18. NUMBER OF PAGES 99	18a. NAME OF RESPONSIBLE PERSON Commanding Officer								
a. REPORT UNCL	b. ABSTRACT UNCL	b. THIS PAGE UNCL			18b. TELEPHONE NUMBER (INCLUDING AREA CODE) COMM/DSN: (619) 553-8429								